Contents

PART I

Growing old: social changes

1 Nature and nurture

Certain human characteristics are entirely genetic, for example the number of fingers, others are entirely cultural, for example the wearing of the kilt in Scotland, but many important characteristics are determined by a combination of an individual's genetic inheritance – his nature – and the environment in which he grows up – his nurture. Height, weight, intelligence, and the manner in which an individual changes with the years are determined by both nature and nurture. The height to which a child will eventually grow is determined both by the genes he has inherited from his parents – on average tall parents beget tall offspring – and by the physical and social environment in which he is brought up. The development of man after he has reached his maximum level of physical size and strength is also influenced by these same three factors: the genes which he inherited from his parents at conception, his physical environment, and his social context.

His genetic composition determines the rate and manner of his ageing. Ageing is a normal biological process which can be identified in every species of plant and animal (see Chapter 12). His physical environment, that is his diet, the water he drinks, the amount of cigarette smoke he inhales, his occupation, and many other factors, influences the probability that he will develop those diseases which have environmental causes. Many of the diseases which commonly occur in old age are not the result of the ageing process but are the consequence of having lived for a long period of time in a certain style. For example, the development of lung cancer at the age of 68 is usually due much more to the fact that the affected person has smoked cigarettes for forty years than to ageing of lung tissue. Diseases develop as a result of abnormal, pathological processes (see Chapters 12–20). The third aspect of change

is a social process, growing old. Retirement is usually considered the point at which old age starts but baptism, school entry, the age of majority, betrothal, marriage, and parenthood also mark the start of stages in the process of growing old. Each signifies the transition from one stage to another with new rights and new obligations. Although these changes are determined by specific chronological age in societies which record time accurately, the age which a society stipulates as the initial age of any stage is, to some degree, arbitrary; consider the rules in different societies concerning the age at which an individual can become betrothed. Similarly, the status of old people in society, their rights and obligations, and the attitudes of young people towards their elders vary widely from one culture to another (see Chapter 3).

Although we discuss these three processes separately they overlap

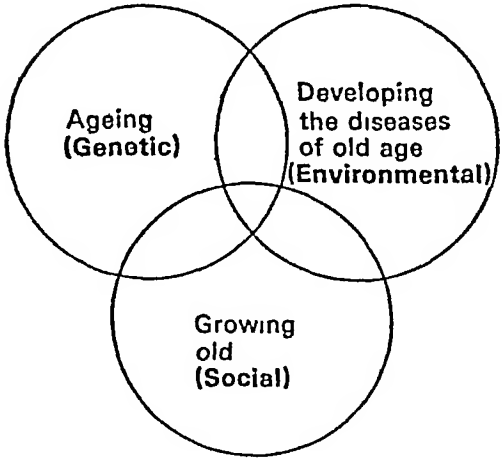

Fig 1

with one another. The distinctions we have made for the convenience of theoretical discussion are not so clear cut in practice Some diseases result from a combination of genetic and environmental factors. Osteo-arthritis of the hips, for example, is partly due to the wearing out of the cartilage covering the joint surface of the upper end of the hip : an ageing process. However, as it more commonly develops in obese people, the environmental factors, both social and physical, which influence an individual's dietary intake must

also be considered as causes. The chronological ages selected to demarcate the stages of growing older are arbitrary, as we have stated, but they are not chosen entirely without regard to the process of ageing. That the retirement age for men should be 65, as it is in many industrialized countries, and not 63 or 67 is the result of an arbitrary decision, but it is a recognition of the biological reality of ageing that it is set somewhere between 60 and 70 and not at an age between 30 and 40 or between 80 and 90.

Each of these three processes is the subject of a separate field of study. Gerontology is the scientific study of ageing, geriatric medicine is the study of the diseases which occur more commonly in old age, and social gerontology is the study of growing old in different societies. As with the processes there is considerable and fruitful overlap. In the zones of overlap new fields of interest form. For

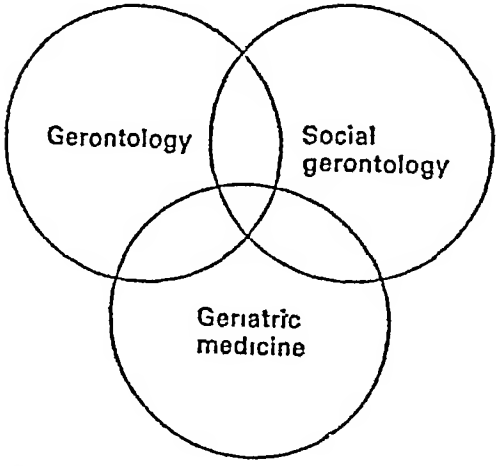

Fig 2

example, psycho-geriatrics, that sub-speciality of psychiatry which specializes in mental illness in old age, incorporates the skills of geriatric medicine, the knowledge acquired by gerontologists about the normal process of brain ageing, and the insights of social gerontologists into the psychological and emotional consequences of retirement and growing old in modern society. Each of the three main fields of interest is not a primary academic discipline but is based on a range of specialist subjects Gerontology uses the tech-

niques of immunology, biochemistry, statistics, psychology, and other scientific skills; social gerontology embraces psychology, sociology, anthropology, history, and economics; and geriatric medicine is based on those same medical sciences which provide the foundations for all other medical specialities.

All these topics we shall discuss in more detail but it is important to emphasize that all the aspects of old age which will be treated separately are considered in isolation solely for simplicity, for they all relate intimately to one another. It is also for reasons of simplicity and brevity that we make generalizations about 'older people', for to generalize about people of any age group is always an oversimplification. Generalizations are made for convenience but they can create false impressions and prejudice (see page 30). Even within a village or street old people are as richly diverse as those of any age. The characteristics each elder shares with other old people, those which we discuss in this book, are few in comparison with the number which are unique to that individual, those which distinguish him as a person. Neither autobiography nor biography nor television camera can capture the uniqueness of each person. A sensitive interviewer can, and Ronald Blythe's book *A View From Winter* is a good portrayal of a number of individual old people but even he uses these interviews to generalize about 'the old'. Generalizations and social policies designed to meet 'the needs of the elderly' are crude and insensitive intellectual necessities.

Common to all older people, however, are the processes of growing old, which we shall describe in the first part of the book, and ageing, which is considered in the introduction to the second part, a section mainly concerned with the diseases which occur in old age. In the third part we shall describe the services available to help elderly people, and finally, in the last part of the book, we look ahead, trying to imagine what old age will be like for those of us who are young today.

2 Growing old

Ageing is a biological process over which man has virtually no influence; growing old is a social process over which he has a great deal of control. Although it is customary to consider old age as starting at the time of retirement from work the process of growing old starts at a much earlier age. Going to primary school, transferring to secondary school, reaching voting age, becoming old enough to buy alcoholic drink in a pub legally, leaving school – these are examples of other formal staging posts in the process of growing old, just as much as the moment of retirement is. Each stage confers certain privileges on the person who is deemed by society to be old enough, that is mature enough, to enjoy them but it also brings its obligations. For example, the age of 18 brings the privilege of being able to buy drink legally and eligibility to vote but it also brings the obligation of being prepared to seek work and of defending one's country if necessary. Retirement brings certain privileges such as leisure and the national insurance pension, but it also brings obligations, such as the requirement that a person should not earn more than a certain amount while receiving a retirement pension (see page 81). The obligations required of a retired person are few but this is not as attractive as it appears because it is the lack of obligations, the feeling of being useless and no longer needed by society, which many people find so upsetting about retirement.

Pension ages

In Britain old age is conventionally considered to commence at the statutory pension ages – 65 for men and 60 for women – at which ages people become eligible for state pensions and at which many

people must retire from work. The same ages apply in Belgium and Austria; in Switzerland the pension age for men is also 65, but that for women is 62; and in America, Canada, the Netherlands, Finland, and Sweden it is the same age – 65 – for both men and women.

There are four important points to emphasize about the pension ages First, that they are not determined by any biological factors; there is no sudden acceleration in the process of ageing at 60 in women and 65 in men The ageing process obviously has some influence on the age chosen as the pension age, and it is sensible to set it somewhere between the ages of 50 and 70, rather than between 20 and 40 or between 80 and 100, but the precision with which the government has settled on 65 and 60 has no biological justification. Second, that there is a wide range in the abilities of people at pension age: some people will have aged much more than others by the age of 60 or 65. Third, that a single pension age ignores the wide disparities between the demands of different jobs; the age for a ripper in a coal mine should be different from that of a clerical worker in an insurance office. Fourth, that the pension age is chosen with regard to social and economic factors other than those affecting the people who will be directly affected by the particular age chosen. The age is set low enough to ensure that sufficient numbers of people retire to create vacancies for unemployed people and school-leavers, and to provide opportunities for promotion within the work-force – most of us wait not for dead men's but for retired men's shoes. Lowering the pension age of men to 60 would increase the number of employment opportunities and reduce unemployment but it would also be expensive. It was estimated in 1980 that a reduction of the pension age to 60 would cost £2,000 million in extra pensions and lost national insurance contributions, so it is impossibly expensive to solve the problem of unemployment by this means

The arbitrary nature of the pension age is clearly illustrated if we consider its history. The first fixed pension age in Britain was set in 1859, when 65 was introduced as the retirement age of civil servants; in 1892 elementary school teachers received pensions at the age of 60; in 1896 Poor Law officials received pensions at 65;

and in the last two decades of the nineteenth century many firms started to pay pensions commencing at an age between 60 and 65. In 1908 the state introduced an old age pension but chose 70 as the age of eligibility, picking this age rather than 65 because the Treasury had calculated that the scheme would cost £7 million if the former age were chosen and £2 million more if the lower age were selected. In 1928, partly in response to the high rates of unemployment which prevailed, the government reconsidered and reduced the pension age for both men and women to 65, the Treasury accepting the higher cost of pensions both because the new pension was linked to an insurance scheme (see page 80), and because it would reduce the cost of unemployment. In 1940 the pension age of women was reduced to 60 because it was appreciated that women were usually a few years younger than their husbands and therefore many a man who had to retire at the age of 65 had to support himself and his wife on a single pension until she too became 65 and qualified for an old age pension. The responsible Act, the Old Age and Widows' Pension Act, also introduced pensions at an age of 60 for women who had contributed to the insurance scheme, so single working women benefited incidentally. There have been good reasons in every case for choosing a certain age as the pension age but these reasons have been social and economic, not biological.

In earlier periods of British history chronological age was also important, although it was not until the sixteenth and seventeenth centuries that the majority of the population knew their age accurately; before Tudor times it was common to give one's age to the nearest round number or to the nearest even number. In the sixteenth and seventeenth centuries the age of 60 was chosen for a number of purposes, for example after the age of 60 prebendaries of Lincoln cathedral no longer had to preach, men were no longer liable for compulsory service under the labour laws of that time, and they could not be prosecuted for vagrancy. The age of 70 had been the upper limit for jury service since the thirteenth century but during this epoch there were proposals for the reduction of the age limit to 60, and for the compulsory retirement of judges at 60.

In other European societies and those which grew from European emigration customs were similar. In Denmark in 1891, for example, the pension age was 60, in America in 1898 it was 65 for men and 60 for women, and the age of 60 has a long history. The ancient Greeks also chose 60 as an important age, as Simone de Beauvoir records in her remarkable book *Old Age*. The Spartans were freed from strict military discipline at 60, whereas in Athens judges had to be over 60 years of age. In *The Republic* Plato described how those who were over 60 had to preside over banquets and prevent excesses. Sixty was also stated by Lao Tzu, in laying down the central tenets of Taoism, as the age at which a man might free himself from the confines of his body and become a holy being.

It is not only literate or industrialized societies, however, which have a social structure in which age is important. All societies recognize childhood as a separate stage and many make further distinctions in adult life on the basis of age; some societies group people into age-sets comprising all those born within a certain period of time, for example eight years in the case of the Galla-speaking people of Ethiopia. Each age-set has its own role in society and the members of each set progress every eight years from bachelor warriors, to married family men, to political leaders and judges, to religious officiants In many other societies there are rules governing the age at which a man passes from one stage to another. The transition to the next stage is often marked by ritual – called by anthropologists the rite of passage, a translation from the French *rite de passage*. Prominence has been given to the *rite de passage* from childhood to manhood but there are also *rites* to mark transition to elderhood.

In British society the transition from work to retirement has its own particular *rite de passage* symbolized by the gift of a gold watch, less common now than formerly perhaps, but still given by many employers. At first sight the gift seems curious because the retired man has, in general, less need to be aware of time now that he is free from having to satisfy his employer's timekeeper but the watch symbolizes the transfer of time control from the employer to the employee: in retirement he will be his own timekeeper.

Retirement

To the government of an industrialized society retirement poses economic problems; to the individual worker and his family it also poses personal problems which may be severe, for retirement affects a person's identity as well as his income. During the course of professional training and apprenticeship a trainee learns not only what to do but how to be a professional: how to act like a doctor, a policeman, a soldier, a teacher, or whatever. This process continues throughout the course of the worker's career. An individual's personality is continually shaped and modified by the nature of his occupation. It comes to dominate his identity. We do not introduce one person to another with reference to his personal attributes, such as his honesty or humility, or with reference to his lineage, as is the case in some societies; we introduce him or her as a toolmaker, a teacher, or whatever, that is by his or her occupation. We say that someone *is* a toolmaker or a teacher, not that he *does* toolmaking or teaching, fusing the individual's identity with his occupation. Retirement brings an abrupt end to the worker's doing of his job, and this inevitably detracts in some way from his being; when a man retires he not only leaves his work, he loses a part of himself. One day he is a busy, important, apparently indispensable worker; the next day he is a pensioner still busy and important at home but much less important in society. It is also obvious that he was not indispensable, as he may have thought, for his previous employer is very soon able to carry on as though he had never existed.

For a small proportion of people this blow is very severe. They become depressed and anxious and may require medical help, but the majority of people who retire seem to cope very well. Most people experience some difficulties, but for many these are little more than they experienced previously on changing from one job to another, except for the fact they they experience a sudden and significant drop in income (see page 76) and lose the company of their colleagues, some of whom have become friends of long standing. These practical consequences of retirement seem to be as important to many people as the more abstract psychological difficulties described in the previous paragraph.

Although we have emphasized that most people adapt successfully, there is no one who is not affected in some way by retirement. The effect varies from one person to another but the reactions of retirement have been classified into five types by a French researcher, Anne-Marie Guillemard. Her five classes were:

1. Those who withdraw, spending much of their time alone at home;
2. those who spectate, using mass media for their entertainment and occupation, but keep busy with household tasks;
3. those who join old people's organizations and clubs with enthusiasm;
4. those who spend most of their time with their spouse, children, and grandchildren, and in leisure activites with people of all ages;
5. those who enter a third phase of life using the leisure offered by retirement to start a new career.

More than one-third of people surveyed were classed in the family and leisure group, with almost equal proportions in the other four groups, and there was little difference between men and women. The significance of such findings have to be interpreted with caution not only because French culture is different from our own but because any grouping of retired people is artificial. Retired people do not merely fall into five types – the response and adaptation of each person is individual and unique – and the findings of research allow only one generalization to be made with confidence, namely that the response of people to retirement reflects their life-style before retirement The man who was always thinking of new ventures in business will probably continue to do so in retirement, whereas the person whose interests were all concentrated towards the family will probably increase this involvement on retirement. This does not mean that an individual's response to retirement can be predicted with certainty; some people adapt better than others whose personality was apparently similar, and factors other than a person's previous personality affect the response to retirement The nature of the job left behind, its physical demands and its satisfactions, obviously influences attitudes to retirement. A man who is digging the road or who spends

two and a half arduous hours commuting to work each day may welcome retirement, although he misses workmates and feels the effects of his drop in income, whereas a man who worked in an office near his home, with freedom to travel occasionally to attractive places to solve interesting problems, may find it much more difficult to adjust. Just as a good education can help people adapt to isolation (see page 110), so it can equip a person with a multitude of interests to fill his retirement, but some well-educated people suffer severely after retirement while those who have had little education experience no difficulty. In an attempt to help people adjust to retirement, pre-retirement education has been developed. The Pre-Retirement Association (PRA) and the Workers' Educational Association (WEA) organize courses with employers in many parts of the country. The PRA also publishes an excellent monthly journal called *Choice* which provides information for 'those approaching, planning and enjoying retirement'. Following this lead, many employers now organize their own courses but it is still only a small proportion of the thousand or so people who retire each working day who have received pre-retirement education. Furthermore, the total amount of education given is insignificant in comparison with the years which stretch ahead – usually only a day or two is allowed by the employer, sometimes only for employees although sometimes for wives too, but the course usually manages to cover talks on health, social security and other financial matters, the social services which are available, leisure facilities, and opportunities for voluntary service.

Retirement also poses problems for some women. Single women obviously face similar problems to men but married women who are working may welcome retirement because they have been doing two jobs, housework and their employment, for too long A woman who is not working may find her husband's retirement difficult. Alone at home for eight or more hours every week-day for the whole of her married life, the housewife has suddenly to share her domain with a husband who may be ill at ease at home initially. Uncertain of what to do, wanting to help, getting in the way – the husband may provoke his wife to anger which comes as a surprise and disappointment to both partners who had been looking

forward to this time. Retirement tests the strength of many marriages.

For women retirement from employment is their second retirement; all have experienced a biological retirement – the menopause – which in our society often coincides with children leaving home. In less industrialized societies women also change their social status when they reach a certain age as the famous anthropologist Van Gennep described in his book *Rites de passage*:

> There do not seem to be any rites of menopause, or of the greying of hair, though these both mark the beginning of a new phase of life which is very important among the semi-civilized In general, either old women become identified with the men and therefore participate in their ceremonies, political activities, and so forth, or they acquire a special position within their own sex group, especially as ceremonial leaders.

In contrast, in industrialized societies women feel they become less important around the time of the menopause if it coincides with their children leaving home and the social consequences of this may aggravate the physical consequences of the menopause.

Retirement prospects

It is impossible to predict with certainty in what respects retirement will be different for those of us who will be facing retirement in twenty or thirty years. A number of factors which will probably alter attitudes to retirement can be identified. In the first place, people retiring in the future will be more accustomed to change – the mobility of society is increasing, people change jobs, place of residence, and social position with increasing frequency. Secondly, the new pension scheme (see page 87) will mean that the drop in income will not be so great as it is now and this in turn may mean that a higher proportion of retired people will be able to afford a car (see page 105) to maintain links with former colleagues and relatives. Thirdly, those who retire in thirty years' time will be better educated or, to be accurate, will have had a longer education, including more pre- and post-retirement education, and therefore may have developed more interests outside work to which they can turn in retirement.

Important though these factors are, a central issue which is unresolved will prove to be of equal importance: the age chosen by the government as the pension age, and the decision whether or not retirement should be compulsory at this age or whether the choice should be left to the individual and his employer to decide – what is called a flexible retirement age. Four main options are open to government:

1. Lowering the pension age of men to 60. This would have cost about £2,000 million in 1980 as more pensions would have to be paid and fewer national insurance contributions would be collected.
2. Raising the pension age of women to 65, which would have saved about £300 million in 1980 but would be very unfair to women in their fifties who were looking forward to retirement.
3. A common pension age of 62 5 years, which would have cost about £800 million in 1980.
4. A common pension age of 64.2 years, chosen because it would cost nothing to implement but would be seen by women as being an infringement of their rights.

The prospect is further complicated by the fact that there are many different retirement ages currently in operation in Britain. Civil servants and teachers can retire at 60, policemen with thirty years' service at 50, and prison officers at the age of 55. In the private sector a similar range is found. In 1976 a Yorkshire branch of the National Union of Mineworkers proposed that the NUM call for a retirement age for underground workers of 60, to be reduced to 55 in the 1980s, on the grounds that mining was arduous work and that the expectation of life of miners – the average number of years of retirement they could hope to enjoy – was less than that of people in other occupations. It was also claimed that miners in other countries such as Russia could retire at 50, but this proposal was modified by the main executive of the NUM who agreed a retirement age of 62 with the National Coal Board in 1977; a scheme which will probably cost about £100 million annually.

During the 1970s America became conscious of the discrimination against elderly people – ageism – as it had become aware of racism and sexism during the 1960s (see page 30). As one step in the

battle against discrimination a bill was introduced to raise from 65 to 70 the age at which employers could require an employee to retire; one of the leading sponsors of the bill was Claude Pepper, then a 77-year-old Democrat from Florida. The bill received overwhelming support in the House of Representatives; 363 in favour 4 against. In Britain fears have been voiced that such a policy would lead to a drop in the number of people retiring and therefore an increase in unemployment but it is by no means certain that this would occur to any significant degree It is true that the average age at which people who work in jobs in which there is flexible retirement age, such as those previously listed, *actually* retire is two or three years above the age at which they *can* retire, but this does not mean that the average worker wishes to continue working rather than retire. The decision about retirement in occupations with flexible retirement schemes, as opposed to compulsory retirement at certain fixed ages, can be fairly easily influenced by financial means For example, if people are allowed to receive their pension while doing a part-time job they may choose to retire but would continue working if told that they will not be paid their pension if they find other employment. From the experience in America it seems that by a suitable combination of financial inducements and education for retirement the number of people who will elect to continue working will not be so great as to aggravate unemployment In 1977 the Department of Employment introduced a 'job-release' scheme offering people who were within a year of retirement a tax-free allowance of £23 a week to be paid until they reached retirement age, provided that they retired and their position was taken by a young unemployed person. The offer was also extended to unemployed people provided they removed their name from the unemployment register, but the early response was disappointing. This does not necessarily mean that people do not want to retire early. A more likely explanation is that the scheme was unattractive because we do not yet know enough about attitudes to work and retirement to design an attractive enough scheme to induce people to opt for retirement in preference to work

Although the whole subject of retirement is hedged about by

uncertainties it seems certain that it will become politically more important in future as economic and technological developments increase the numbers of people who become redundant or unemployed, because retirement is one method by which the government can regulate the size of the work-force and create employment. The silicon chip – the micro-processor – may have as great an influence on the debate about retirement as the great recession had on the debate in the 1920s.

3 The status of old people

The act of retirement brings not only a change of occupation, from being 'employed' to being 'retired', but also a change of social status – a drop in status. The low status of retired people is symbolized by the fact that their income level is, on average, much lower than that of the average income of an employed person. They receive less income because society values those who are currently producing wealth, directly or indirectly, more highly than those who have done so in the past. Furthermore, the low level of income of elderly people not only symbolizes their low status but also perpetuates it, because people who are limited in their ability to consume goods and services, having little money left to spend after they have purchased the necessities of life, are of low status in a consumer society like Britain. Their status and income remain low because they are, as yet, unable to change their social position by concerted political action. On retirement people move from a position of political power, as a member of organizations such as the British Medical Association, the National Union of Mineworkers, or the National Union of Teachers, to a position of relative political impotence. Although people over pension age form a large proportion of voters they do not vote in a concerted fashion to improve the lot of elderly people. Retired people are not politically apathetic; on the contrary, in many constituencies they turn out to vote in as great numbers as voters in other age groups, but they vote for what they consider to be the good of the country and not the good of their own group. Although this attitude is praiseworthy, it does not raise their status or income.

The fact that they no longer occupy key positions in the workforce is the main reason why retired people are, and remain, of low status, but another important reason is the increasing frequency of

disability in old age. In people under pension age disability is a cause of low social status because it can, unfortunately but not infrequently, lead to unemployment. In people over pension age disability can also cause social problems, principally by its effects on a person's mobility. Older people are less mobile than younger people because disabling diseases are more common (see page 147) and they less frequently have access to a motor car.

People who cannot go out unaided are not only excluded from many leisure activities and the homes of relatives and friends, they are unable to go to the town hall, or see their councillor, or visit their MP's 'surgery', or go to the Social Security office, or the health centre, or the Citizens' Advice Bureau, or the Age Concern office, or any other place where they would claim their rights.

To summarize, we argue that elderly people have low social status imposed on them by compulsory retirement and that their low level of income both reflects and perpetuates their low status. In our opinion, the reason that elderly people have so far been unable to raise their status is that they do not act as a united political force, that many are content with what they currently receive (see page 53), and that many of them are insufficiently mobile to lobby for social change.

Status in the past

Elderly people have not always been of low status; there have been social orders in which they have occupied the most exalted position. In his essay in praise of old age *De Senectute* written in 50 B.C. when he was 63, Cicero maintained that 'if there were no old men there would be no civilized states. Old age is far from being deprived of good council; on the contrary, it has these qualities in the highest degree. States have always been ruined by young men socially, and restored by old.' The term 'Senate' is derived from the latin *Senex*, which means aged, and the name of the ruling body of Sparta, the Gerusia, was derived from the Greek word for old. Gerontocracy, the right to rule by reason of one's age, was common in many societies, but not universally so. For example, the word 'Pope' is derived from the Greek for 'fathers' but not all Popes were

old – indeed, there was a period in the Middle Ages during which young men and boys were appointed to the Papacy. Nevertheless the older people in a society were often the rulers. For example, in 1615 Bishop Babington advised that 'be the place ecclesiastical or civil, an aged man ripe in judgement and experience' should be chosen to fill it rather than 'a younger destitute of such mature wisdom and knowledge'.

Certain words survive to our own day which illustrate this gerontocratic tendency. For example, 'Presbyter', as in the Presbyterian Church, is from the Greek word for elder. The word 'elder' first appeared in the dark ages as the title of the man who occupied the position formerly held in Anglo-Saxon society by the patriarch of his clan who had been called the *Aldor* or *Ealdor*. As a political title it became *Aldorman*, then alderman. This title was also adopted by the powerful trade guilds and as the aldermen were often magistrates by virtue of their position in the guild the term entered local government, the alderman being the principal assistant of the mayor. After the modern system of local government was introduced in the nineteenth century both the mayor and aldermen were elected by the councillors, the aldermen being chosen from among the councillors themselves or from those who were qualified to be freemen. Although the aldermen did not have their own chamber in town or county hall their influence was analagous to that of the House of Lords; they were considered to be a stabilizing force and one which would not fluctuate from election to election. Although it was acknowledged that there were many advantages to the aldermanic system it was felt that aldermen were undemocratic, as they were not directly elected by the electorate, and they were phased out when local government was reorganized in 1974. The London boroughs were the last local authorities to lose their aldermen, preserving their status until 1978, and they now exist only in the City of London whose charter, which was granted by William the Conqueror, still embodies many Saxon principles.

Almost every society which has been studied has been gerontocratic at some period in its past. The Aztec, the Inca, the Maya, the major tribes of Oceania and Africa, the Aborigines, and many others have all been ruled by old people, some of them are still, but

in Britain, as in other industrialized societies, the status of old people has declined.

When and why

If we do accept that the status of old people was formerly higher than it is now, we must address ourselves to two questions: when did this drop in status occur, and why did it come about? These questions are deceptively simple and the answers to them are complex.

Of one fact we can be relatively certain; it did not occur at the time of the Industrial Revolution. It is widely assumed that the Golden Age of living for older persons was disturbed and undermined by the Industrial Revolution A cosy picture of the life of old people in the pre-industrial period has been painted by many writers, some of them respected students of ageing, featuring the old man at the hearth, puffing his pipe, respected and revered, being consulted on matters relating to the farm, with the old woman in her lace cap sewing and giving advice on cooking, child-raising, and housekeeping. Such are the stereotypes of the images of old age in pastoral times; a life-style, it is claimed, rudely shattered by the clattering machines of the Industrial Revolution which required workers to learn skills from their employers instead of their parents.

This golden image is inaccurate Although we long nostalgically for the good and simple life of merrie England that life was often mean, cruel, and hard. The position of old people in the family was much as it is today, and neither industrialization nor the inter-related phenomenon of urbanization was solely responsible for the drop in status of the elders The suggestion that the Industrial Revolution was not the turning-point for elderly people should not be surprising. Anyone who looks for clearly discernible 'turning-points' in history is doomed to disappointment; as Christopher Hill, a famous Oxford historian, wrote: 'when I was a boy at school my textbooks of English History used to give the impression that one fine day in 1485 Englishmen woke up and said with surprise "The middle ages are over – modern times have begun " This

view now seems naive and silly.' Battles and Acts of Parliament can be precisely dated but a change in the consciousness of society, such as the decline in status of old people, takes place gradually. From scraps of evidence carefully analysed by social historians it seems that the status and therefore the power of older people waned continually since earliest recorded times. At times it has waned more quickly than others, at times it seems as if the power of the elders increased, but the general trend has been a decline. The decline has sometimes been difficult to identify, for example in sixteenth- and seventeenth-century England much was written and said to support the idea that older people were wiser and should rule but the important posts in that society were held by middle-aged people of between 40 and 60. In a fascinating study called *Growing Old in America* David Hackett Fischer suggests that the period between 1770 and 1820 was the time of transition between high status and low status but the American experience is different from that of European societies because of its telescoped time scale. In Britain old age has gradually declined in status at a rate determined by the other broader trends which were responsible for this decline.

In trying to explain why the status of old people has fallen, and is still falling, it is helpful to consider the reasons why they were formerly considered to be of importance and how these factors have changed. One simple reason for their high status is that they were rare. Nowadays old people form a large proportion of society (see page 245) and it is no longer remarkable for someone to survive to the age of 70: in the twentieth century 20 per cent of babies survive to this age; in the eighteenth century only 3 per cent lived to threescore years and ten and those who did were often regarded with awe for their achievement The second reason for their importance was the essential part played by elderly people as repositories of knowledge. It was they who were to direct rituals and to give advice on farming, hunting, fishing, and crafts which were based on local produce using locally produced tools. The importance of this type of traditional knowledge has been continually undermined as new technology has developed. The introduction of the heavy mould-board plough (the *carruca*), for instance, transformed

agriculture in the ninth and tenth centuries, playing an integral part in an agricultural revolution whose traces can still be detected as the undulating ridges and furrows of modern fields. Related to this, changes in crop rotations, in the size of fields, in the system of land holding, and many other developments took place, all of which lowered the status of the elders who could not give much useful advice on these innovations People came to depend less on proverbs and more on proven facts As the pace of technological invention has accelerated, therefore, so has the status of old people fallen.

Although they were of decreasing value in this sphere their knowledge of customs and rituals was still of some use, until the invention of printing and the spread of literacy. When it became possible to print laws and regulations, calendars and timetables, herbals, prayer books, maps, and many other essential pieces of information, the experience, and therefore the status, of the elders was seriously devalued. Changes in the religious belief also subverted the status of old people. The Reformation resulted in parents and children having different religions, the former Catholic and the latter Protestant, and this frequently led to conflict; as one person wrote, 'my father is a doting old fool and will fast upon the Friday; and my mother goeth away mumbling in her beads. But you shall see me of another sort, I warrant ' It must be said, however, that the effects of the Reformation were not all inimical to the status of old people. The Fifth Commandment remained an important text and the Puritans also believed that God had saved those who were old: 'if a man is favoured with long life it is God who has lengthened his days', wrote Increase Mather. The Calvinists also exalted old age, believing that those who survived old age were 'the Elect', the chosen few for whom Jesus had died.

These influences have not all operated with the same force at all periods in history. The influence of the Reformation was greatest in the sixteenth and seventeenth centuries, during which the influence of printing also became more widespread. In the eighteenth century the Enlightenment opened the minds of men to new ideas and exploded many of the old ideas which were shown to be fallacies. In the nineteenth century the spread of egalitarian ideas

attacked the position of all traditional holders of power, including elderly people, and in the twentieth century all these influences have come together to devalue experience and place a premium on youth.

Old people as a social problem

In recent years elderly people have attained a new social status: they are recognized as a distinct group whose members not only share the same problems but pose problems for the rest of society.

The attitude of those members of a society who are powerful and wealthy towards those who are not is determined by many factors which can, however, be considered under two main headings: the compassion they feel for the sufferings of those who are impotent, and the control they feel they must exercise for self-protection; that is to say, help is given to poor people not only for their benefit but to reduce the risk that they will turn to crime or revolution. The first laws which were directed at the problem of poverty were drafted more to protect society from idle vagabonds and rogues than to help the paupers. The Poor Law of 1601, although still primarily punitive, showed greater compassion but it was not until the nineteenth century that an enlightened view of poverty began to be more important than the desire to control the indigent and protect the wealthy. In the 'New' Poor Law of 1834 the 'elderly infirm' were considered only as one sub-group of the poor and their problems did not receive special attention; they had to share the workhouse with people impoverished by many other causes, such as insanity or disability. All lived, or existed, together in the General Mixed Workhouse. From 1890 onwards elderly people received separate consideration and regulations were issued, partly as a result of the recommendations of the Royal Commission on the Aged Poor, which required the workhouse to give elderly residents a better diet, tobacco, and a greater degree of privacy. In 1909 Sidney and Beatrice Webb published and largely wrote their Minority Report of the Royal Commission into the Poor Laws and Relief of Distress which was probably more influential than the official Majority Report published by the government. The

Minority and the Majority Reports formed two firm planks in a platform for social reform although many of the reforms which were suggested took many years to implement.

After this period of interest in the first decade of this century little concern was shown for the problems of elderly people except for the reduction of the pension age to 65 in 1928, a move which also benefited the unemployed (see page 7), until the 1940s when the Beveridge Committee paid close attention to their problems. This view derived perhaps less from the compassionate angle of the Webbs and more from the perspective of public servants alarmed by the prospect of the costs which would inevitably increase as the numbers of people over pension age grew. Nevertheless they tackled the problem boldly and humanely, and the National Assistance Act of 1948 finally dispelled the Poor Laws; Section 1 of the Act was explicitly titled 'Supersession of existing poor law'.

Since 1948 central government has paid increasing attention to old people both in reports dealing specifically with their problems, such as the 1954 Phillips Report on the *Economic and Financial Problems of Provision for Old Age*, and in the context of general reports on health and social service planning The tone of such reports suggests that government has been as concerned with the social and economic problems created by the increasing dependency of an ageing population as with the plight of individual old people but every report has been combined with an enlightened humane spirit. The culmination of this trend was the discussion document called *A Happier Old Age* published by the government in 1978 to stimulate ideas which were included in the White Paper (see page 246).

The privileged underprivileged

Society now recognizes that other disadvantaged groups have special needs Poverty, immobility, and political impotence – those factors which both symbolize and perpetuate the low status of elderly people – are also the lot of many young disabled people, single parents, unemployed people, and those in certain types of occupation. They too are of low status and are disadvantaged in

the same way but elderly people enjoy many privileges which unemployed and young disabled people and single parents do not and retired people have been called 'the privileged underprivileged' because they receive benefits for which these other groups are ineligible. For example, the supplementary pension is 20 per cent higher than the supplementary allowance paid to people under retirement age because elderly applicants receive what is termed the 'long-term addition' from the first week they receive their supplementary pension, whereas young people only receive this allowance after they have been in receipt of supplementary allowance for two years Another example of their preferential treatment was the £10 Christmas 'bonus' given to pensioners by the government in 1978. Many of them were in need of a lump sum to help with the rates and with the heating costs but a large number of pensioners were in less need of financial help than many single parents with two small children who received nothing. In addition to these social security benefits people qualify for many other privileges which young disadvantaged people do not. Senior Citizens' Railcards, cheap admission to bingo, football, and cinemas, concessionary rates at hairdressers, help with bus fares, Christmas parcels from voluntary societies, and index-linked National Savings Certificates are only some of the advantages they enjoy.

There are sound practical reasons for some of these privileges; for example, supplementary allowance is usually only paid to people for a short period of time and it is envisaged that recipients will usually work again, whereas supplementary pensioners will never work again and require the long-term addition to help them replace worn-out clothes or bedding and essential household equipment However, elderly people receive some of these privileges not so much because their need is greater than that of young disadvantaged people but because society is more sympathetic to the plight of its elders than to that of unemployed people and single parents Impoverished elderly people are considered more deserving because their poverty is not thought to be 'their fault', although this is a view which is not shared by all elderly people Some of those elders who have saved or earned sufficient pensions to render them ineligible for a supplementary pension and its attendant

financial benefits have very bitter views about those who are impoverished.

These special privileges reflect society's gratitude towards elderly people for the contribution they have made but it also reflects other, less praiseworthy, attitudes towards its elders which are the consequence of the guilt felt by many people (see page 33). Rather than old people being given a proper place in society they are given a few well-publicized special privileges which are of benefit to them, it is true, but are also beneficial to society at large which uses them as evidence to prove to itself that it is treating its elders well.

4 Attitudes towards old people

Love, veneration, and hostility

The attitudes of society towards a person cannot be completely deduced from his status alone; some men of high status are loved, others are hated. In the past, when old people were of high status, attitudes towards them were not always loving and respectful although it is believed by many people that this was the case. Many were loved because of their personal qualities, that is they were loved as individuals, but elderly people as a group were held in awe, because there were so few of them (see page 20), and in respect because of their powers, such as their knowledge of essential rituals, but there were other, less pleasant attitudes towards them. The *Shorter Oxford English Dictionary* defines 'veneration' as 'a feeling of respect and reverence', from the Latin verb *venerare* meaning to worship, but veneration does not necessarily imply love. Old people may have been respected but they were not necessarily loved, in fact they were often disliked intensely and even hated. The elders did not occupy positions of high status solely because society unanimously accepted that they should do so on account of their attributes: they remained in high status in their positions of power because they would not relinquish these positions. Kings did not abdicate; merchants did not retire; landowners did not gracefully hand over their estates to their sons. They clung on to their powers and kept their children in subordinate positions and the tension between the generations often increased over a period of time in a vicious circle. The elders held firmly to their power; their children resented it; the elders clung on to their power even more tenaciously in fear of what would happen if they lost it; and their children's resentment turned to hatred The story of King Lear served as a warning to old people in Shakespeare's

time for in the play Lear relinquished his power to two of his three daughters, Goneril and Regan, who immediately placed cramping restrictions on his life-style which eventually drove him from his former home, and his mind.

The most accurate measure of the attitudes of one group in society towards another is not, however, revealed by studying the attitudes towards those members of the group who are in positions of power; it is better to judge attitudes towards those members of the group who are weak and helpless. Although we have argued that elders were, in general, of higher status in the past than they are today not all were in positions of power and for those who were not life was hard and cruel. For example, although the Romans established old people's homes – called *gerocomeia* – no more than a small proportion of old people were eligible and old slaves often starved to death, in spite of exhortations to respect elderly people such as that mentioned in Cicero's *De Senectute*. Neither did impotent old people fare well in Christian societies in earlier times in spite of the Fifth Commandment, 'Honour thy father and thy mother: that thy days may be long upon the land which the Lord thy God giveth thee' (Exodus 20. 2), and the proverb that 'the horny head is a crown of glory in it be found in the way of righteousness' (Proverbs 16: 31). In seventeenth-century England old age and the inability to work brought poverty to many of those who survived to old age and the Poor Law of 1601 was denounced by one critic who felt that it removed an essential stimulus to work – 'the terror of starving in old age' – although the Poor Law provisions could not be described as generous. Richard Steele, the essayist, described prevailing attitudes towards old age in trenchant fashion: 'old people commonly are despised, especially when they are not supported with good estates'. In America attitudes were similar. old slaves with uncaring masters were left to starve and widows without property were sometimes driven out of town by people trying to keep down their 'poor-taxes'.

Attitudes towards old people were not universally hostile, and the number of almshouses and hospitals established for the benefit of indigent elderly people is testimony to this, but it was not until the nineteenth century that the attitudes of society in general began

to mellow. This mellowing of attitudes was not, however, specifically stimulated by the plight of old people: it was only one aspect of a change in attitudes of powerful and influential members of society towards all those who were weak and disadvantaged, not just elderly people The spirit of the Victorian age became progressively more altruistic, and was both expressed and formed by the work of the great writers of the Victorian social novels – Charles Kingsley, Benjamin Disraeli, Mrs Gaskell, and, most influential of all, Charles Dickens Committed, compassionate, and prolific, Dickens dramatized the problems of Victorian Britain. Although few of the many old people in Dickens are cast as the victims of the social order which he was criticizing, Betty Higden who lived in fear of the workhouse in *Our Mutual Friend* is a notable exception, it was probably obvious to many readers that the impoverished elderly people in their parish were affected by the injustices Dickens attacked just as much as were his famous children such as Oliver Twist or Little Nell. From what we know of Dickens we can assume that the reason that he paid comparatively little attention to the plight of elderly people was that they were so few in number in comparison with the hosts of deprived children who populated the cities of nineteenth-century Britain. Attitudes towards old people continued to grow more compassionate in the twentieth century, again as part of a general shift in attitudes which gradually led to the break-up of the Poor Law, and the attitudes which it perpetuated, in 1948 This reflected genuine changes in the consciousness of society but was also made possible by the growing wealth of Britain during the course of the last century and a half (It is important to appreciate that the ethical values of society are influenced by its economic circumstances: attitudes develop in wealthy societies partly because of the increase in wealth)

In *Old Age* Simone de Beauvoir describes the harsh treatment of disabled elderly people in tribes living on the brink of extinction. Most of these tribes and customs have died out in this century but it is probable that very similar practices were common in Britain in prehistoric times In some tribes the elders were put to death as soon as they showed any signs of weakness not always simply

because they ceased to be productive but sometimes because the members of the tribe believed that an elder's strength was passed on to the community when he died and that the elder must therefore be killed before his strength had ebbed away. For example, the Chitume, the high priest of a people in the Congo, was put to death as soon as his health began to fail and the old men of the Sudanese Dinka who were rain-makers were buried alive, willingly and without resistance, so that the community would receive their strength. In other tribes such beliefs were not held and old people were simply neglected when they were unable to continue making a contribution. In some cases they were just not given sufficient food to survive, the tribes preferring to distribute their slender resources among the children and active members; the Yakut of Siberia and the Ainu of northern Japan acted in this way. In nomadic tribes an elder who was unable to keep up with the nomadic migration was simply left behind, the Siriano in Bolivia were seen to leave old people to starve as they moved from one part of the forest to another in their desperate search for food. The Hopi, Crow, and Creek Indians, and the Bushmen led the disabled old person to a specially built hut where he was left with little food or water, and the Eskimo left the elder on an ice floe or in an igloo, although some elderly Eskimos preferred the quick death of suicide.

Even today the plight of old people in many poor societies is very hard In some developing countries old people are still venerated and supported by their families but in an increasing number of countries the impact of new cultures and technology has caused a sudden change in attitudes towards the elders: the trends which we suggest took place over hundreds of years in Europe have been telescoped in time. This factor, combined with the migration of large numbers of young people to the cities and with inflation, which makes it difficult for them to send regular remittances to the old people in the villages, has had the result that large numbers of old people in under-developed countries now exist in poverty and degradation. War on Want, Oxfam, and Help the Aged have responded to this need but the problem, particularly in Africa, is on an immense and growing scale.

Underestimation, ageism, and over-protection

The compassionate attitudes towards the problems of old people which prevail in developed countries have resulted in social policies which make our elders better off, in many respects, than old people have ever been but some of these attitudes also create certain problems for elderly people who are often underestimated and at the same time often over-protected.

Underestimation and ageism

A greater understanding of the effects of normal brain ageing and dementia has certainly led to a more sympathetic attitude towards those who are affected by either condition. For example, they are now regarded as ill and treated with sympathy whereas in earlier times they were often incarcerated in the General Mixed Workhouse on account of their poverty This has been a satisfactory consequence of our recognition of the diseases of the brain but other consequences have been less satisfactory.

Many people assume that all elderly people, especially those in their eighties and nineties, have brains which have degenerated to such an extent that they are incapable of argument, rational discussion, or learning and that any mistakes which they make should not be corrected as they would be if made by a younger person. Consider, for example, a lady aged 93 who says that her son came to see her two days previously when the person to whom she addresses this remark knows that it was three days before. The response which is often given by a younger person to such a mistaken statement is 'that was nice' or 'oh really?' whereas the response to a person of 43 or 33 who had made a similar mistake would have been to correct the mistake, if necessary arguing the point with reference to relevant evidence, such as other events which had taken place on the day of the visit. The results of continually agreeing with someone, irrespective of whether the person is correct or not, are very serious We all make mistakes, many of them every day, and we depend upon other people bringing our mistakes to our attention to keep us in touch with reality. If our

mistakes were not corrected by others we would detect very few of them ourselves because we do not continually monitor our thoughts and speech to check for errors. We rely on others to do that for us. At first the mistakes which pass without correction may only be minor but the cumulative effects of never having one's minor mistakes corrected over a period of time can be very serious and the mistakes which are made inevitably become greater and greater. The failure to correct the mistakes of our elders is of course not always based only on an underestimation of their abilities but also on an erroneous idea that it is disrespectful to correct one's elders. It certainly is in certain situations, but in general it is wrong and disrespectful not to correct the mistakes of one's elders, for it is a mark of disrespect to agree with someone automatically rather than listen carefully and disagree if necessary. Many a woman knows how infuriating it can be if her husband mechanically answers 'yes dear' when it is obvious that although he has heard her speaking he is not listening to what she is saying. This happens to old people very frequently. In the short term it is infuriating, in the long term it can cause a deterioration in the elder's mental condition.

Some young people make the even more serious mistake of believing that ageing and the development of dementia are identical processes and that all elderly people are 'dementing', or 'senile', a term which should never be used. The belief that all elderly persons have dementia can lead to the diagnosis of dementia being made in an elderly person whose behaviour is bizarre.

Mrs S. is 82 and lives in a block of sheltered flats One morning she was observed by a neighbour walking to the shops at 7.30 a.m , one and a half hours before they opened. The neighbour took her by the arm and led her back to her flat. Ten minutes later the same neighbour saw her walking to the shops once more and took her back to her flat a second time. This time Mrs S. became disturbed; the GP was called, he prescribed a tranquillizer, and she slept all day. At 5.30 p m. she walked to the common room of the block of flats to play bingo, which did not start until 7.30 p m. She was taken back to her flat by one resident, another came in to make her a cup of tea, a third called the warden, who rang the GP again and contacted her son At this point the woman became very disturbed, claiming that

people were trying to kill her, and the GP said he would ask for a second opinion from a consultant psychiatrist.

It was then discovered that her son had turned her clock *back* an hour instead of turning it *forward* the previous evening which had been the spring equinox.

Even if the presence of dementia is certain, an elderly person is still capable of rational discussion, although many people assume that the diagnosis of dementia means that the elder is incapable of any rational thought. Even trained professionals may make this mistake.

A qualified nurse is pushing the drug trolley round the day room of a psychogeriatric ward

Nurse. 'Fred, come and get your medicine.'

Fred walks over towards her. She holds out a teaspoon containing two pills.

Fred: 'I'm not taking those, they make me drunk.'

Nurse: 'Fred, take your medicine please.'

Fred. 'No, they make me drunk.'

Nurse (winningly): 'Now Fred, take your medicine or you won't get better'

Fred: 'But I'm not bad at the moment.'

Nurse (impatiently): 'Fred, take your pills'

Fred puts the pills in his mouth and turns angrily away.

The nurse turns to a nurse in training, who was observing how she conducted the drug round and said 'He gets very aggressive at times you know.'

Not only did the nurse miss the patient's report of drug side-effects, she ignored Fred's conversational openings and created anger and frustration by underestimating his abilities.

This attitude may be said to be a prejudice. Many people assume that all elderly people are of declining intelligence and are unable to learn or adapt, and so start any conversations with, or consideration of, an elderly person on the basis of this assumption. This type of prejudice has been called ageism. The ageist attitude is one which lumps all people over the age of 65 together as 'the elderly' and we admit that, in one way, we are guilty of an ageist approach ourselves. Any generalizations about elderly people, such as those which compose great parts of this book, must be treated with caution. The members of any group which is defined by a single characteristic such as 'the elderly', 'the West Indians',

or 'the adolescents' always differ from one another in many more respects than those they have in common. We prefer the use of the term 'elderly people' rather than 'the elderly' because it emphasizes that those who are more than 65 years old are still people. They are all distinct individuals and to call them all 'the elderly' implies that their age is their most important feature. It is true that all elderly people share some features, such as the attitudes which young people have towards them and, with a few exceptions, their low income. It is also true that all the members of the same generation have been influenced by the same social events, such as the Great War, but the age range from 65 to 105 encompasses two generations, although even the term 'generation' is a generalization. Each person over the age of 65 is a person, individual and unique, not just one of 'the elderly'.

'The elderly' is only the latest in the series of terms which have been used to describe people over the age of 65. 'OAPs' and 'pensioners' have been used but are disliked by some people because of their working-class image; 'Senior Citizens' appears an attractive title but has never become popular; 'the aged' was commonly used in the nineteenth century but is now less popular perhaps because it seems to have a more decrepit image than 'the elderly', and the same objection can be raised to 'the old'. Perhaps it is naïve and unrealistic to hope that the term 'elder' could be reintroduced to the common currency of our language, although we think that it is the best term. Of one principle, however, we are certain – that it is wrong to use an adjective as a noun, a figure of speech called metonymy, when generalizing about any group. Of the terms currently in use we much prefer 'elderly people', provided that it is emphasized that any generalizations about people of a certain age are to be treated with great caution. Ageism is as reprehensible as racism or sexism and it can be as damaging and demeaning to individuals

Over-protection

It is to the credit of our society that we do not allow people who do not have the power to provide for themselves to suffer the degree of

deprivation and degradation which was common in nineteenth-century Britain, and which is still common today in many countries, but this protective attitude can go too far. It is good to care for elderly people, to do those things for them which they cannot do themselves, but it is not good to do everything for them. The minds and bodies of young people remain fit and agile not just because they are young but because they are constantly involved in decision-making and activity. Everyday life is therapeutic for mind and body and if decisions and activities are taken away from people deterioration is inevitable. Old people lose some decisions and activities unavoidably, for example by becoming disabled, but they lose others because of the type of care they are given.

Consider the change in life-style involved in moving from one's own home to an old people's home In one's own home life was full of decisions from the moment of waking, the timing of which was itself decided by the old person. 'Should I put the light on? Should I put the fire on, or should I put my coat on and leave the fire off until later to save electricity? What will I have for breakfast? Should I ask the home help to buy more butter today or wait until next week? Is the toast done?' These are only a few of the decisions which have to be made in the first hours of the day at home but which are unnecessary in many old people's homes. Freedom from certain decisions has its benefits. It is of little advantage to an elderly person to live in terror of debt but it must be emphasized that worry is part of normal life and keeps the mind active. For example, it can be argued that the decision of whether to put the fire on or whether to postpone this action and sit in one's topcoat for another thirty minutes in discomfort is similar in nature to the decision of whether to try to hold one's water until one can reach, or be taken to, the toilet or whether to just let it pass where one is sitting. Consider also the activities which such decisions initiate. Putting on the light; bending to light the fire; turning a tap to fill the kettle; reaching for a plate; opening the bread bin; tugging at a drawer to find a knife; switching on the grill – these are only a small sample of the activities which an elderly person has to perform at home but which are unnecessary in many old people's homes and nursing homes because the heating and lighting are

turned on by the staff and breakfast, sometimes with toast already buttered, is brought to the table at which the person sits and waits. Of course it is nice to prepare the breakfast for someone who has had to struggle and work hard all her life, cooking and caring for others, but the muscles and joints employed in making tea and toast are those which are also used in such necessary tasks as dressing and undressing and the muscles and joints used in walking to the coal-house and back are those used in walking to the toilet.

The staff of old people's homes are often criticized for supporting this inactivity in the homes, for allowing the old people to 'degenerate into cabbages', as one *Daily Mail* reporter crudely expressed it, but the inactivity does not so much result from staff attitudes as from society's attitudes. Some members of the public, and their elected representatives the councillors, criticize the staff of a home if they try to encourage resident participation in bed-making, laying the tables, or any other of the household tasks of the home. The relatives of residents may also be critical. 'Why won't you let my mother stay in bed all the time if she wants to?' or 'If I buy a wheelchair will you wheel my mother to the dining room like those others?' are two typical questions directed at staff who are trying to encourage a resident to be active to prevent her becoming more disabled. The over-protective attitude of relatives is sometimes partly due to a feeling of guilt that they should be the ones who are looking after the elder, but it is also due to their belief that 'caring for' old people is synonymous with doing everything for them. Finally, the staff have to cope with the attitudes of the residents themselves Some residents consider that they are in the home to be 'looked after' and ring the bell for a member of staff whenever anything requires to be done even if they are capable of doing it themselves, saying, for example, 'You pick up my cardigan, you're paid to do it', and such attitudes are aggravated by the fact that some residents in local authority homes pay whereas others do not. For example, an elderly person who owned a semi-detached house worth about £20,000 (in 1979 terms) before she was admitted to a home is required to pay the full cost, more than £80 weekly, whereas someone who had no resources other than social security is obviously unable to make such a payment. Many of those who

pay from their savings, or from the capital realized on the sale of their home, are aware that those residents who have no capital receive only about one-fifth of the amount of pensions which they received in the community and that, in most cases, the reason that such residents have no capital and therefore cannot pay cannot be said to be 'their fault'. Some of those who pay from their own capital, however, are bitter and the source of their bitterness is understandable. Paying more than they ever paid for the best holiday they ever had – for few of them would ever have spent £70 a week in a hotel – they see other residents, whom they know to be making no direct contribution from savings, receive exactly the same food, living accommodation, and service; they may even share a room with them. It is not surprising that people who feel aggressive in this way make demands on the staff and take umbrage if asked to care for themselves although the decisions and activities involved would be beneficial for them.

In spite of these attitudes, staff in many homes are managing to involve residents in more decision-making and activities, but it is a slow process requiring the education of the public, councillors, relatives, and residents that 'caring for' an individual does not imply that everything should be done for her; nor does it mean that they should run no risks, for public attitudes to old people 'at risk' are another facet of the over-protective attitude.

All of us are at risk every day; some of us, for example cigarette smokers and car drivers, are more at risk than others but little anxiety is generated among members of the public by risk-taking behaviour in young people No one phones a man's GP or the Social Services Department if he is observed chain-smoking high-tar cigarettes but if an old person is thought to be 'at risk' then public concern is quickly aroused. Some people do run higher risks in old age than they ran when younger: some are at risk of hypothermia (see page 193), others of falling (see page 157); some are at risk of setting fire to their dwellings, others at risk of illness because they forget to take their medication (see page 205). It is certainly wrong to let elderly people live with unnecessary risks. In some cases correctable medical factors can be identified which have put the elder at risk, for example thyroid disease which increases the risk of hypothermia (see page 194); in others modifiable environmental factors

exist, such as a dangerous paraffin heater; but when all such factors have been corrected and the elderly person wishes to continue to live at home, although she is still 'at risk', she should be allowed to do so. The anxiety of neighbours, relatives, and friends may lead them to try to persuade the elder that she should go into a home 'to be looked after' and to put pressure on the health and social services to 'do something'. This pressure can be very strong and difficult to resist but in most cases it is right to resist it, leaving the elder at liberty, albeit at risk. There are exceptions to this principle. Some elderly people develop a mental disorder of such severity that their decisions and opinions can no longer be considered completely valid and they are compulsorily admitted to hospital but the majority of old people are aware they are at risk and are upset by the over-protective attitudes which prevail in society.

Why should people feel so protective towards old people? In part it reflects their appreciation of the fact that many old people are at greater risk than younger people and a genuine desire to help. In part it reflects the ageist attitude which presupposes that older people are not able to appreciate the risks they run, but it also results from deeper feelings not dissimilar to those which gave rise to accusations of witchcraft in the past.

The number of people accused of being witches increased dramatically in the sixteenth and seventeenth centuries in England, as in some other European countries. The typical person accused of witchcraft was a poor old woman, usually single, and although the reasons for this sudden upsurge of accusations are extremely complicated two main themes emerge which are of relevance today. The first important feature is that the Poor Law of 1601 caused confusion among those who were well off because when someone came begging they were uncertain whether they should give help directly or whether the parish should provide help from the poor-rates which were levied. As a result of this a higher proportion of beggars were probably turned away than before the introduction of the system of Poor Law relief. Secondly, people felt a greater burden of guilt in this era than they had experienced before the Reformation. If one ignored poverty or turned a poor beggar woman from one's door one was able to confess or make

financial atonement to the pre-Reformation Church. These means of expiation were closed to Protestants after the Reformation. When misfortune occurred, an illness or the death of one's cattle for example, it was easier to think of the old woman who had cursed one as she had been turned away from the door than to accept that these problems were the result of a lack of charity. The situation is not dissimilar today. People feel guilty about the plight of an old person living in dirt and isolation. They know they could help in many ways if they gave up some leisure time to the task but they are uncertain about what they should do and what the health and social services, for which they pay large amounts of rates and taxes, should do. Nowadays the old person who is the source of this guilt and ambivalence is not accused of witchcraft but is put under pressure to go into a home 'where you can be properly looked after'. The term 'witch-hunt' is still in use but the witches, the focus of community anger, are now the professionals whom the public think should be caring for old people, and the witch-hunt takes place when an old person is found who has died apparently through neglect, although one study of such deaths suggests that most of the people had chosen this way to live and to die and were aware of the risks they were running.

Family attitudes

Do children care?

Some professional and voluntary workers bemoan the fact that families 'don't care' for their elders, maintaining that they often try to have them admitted to institutions by unscrupulous means and that they frequently abandon those who are admitted. In November 1978 an article in the *Doctor*, a newspaper circulated to all general practitioners, bore the headline 'Granny-dumping trend' and stated that in Glasgow's Royal Infirmary, a premier teaching hospital, one bed in four was occupied by 'discarded old folk'. More seriously there have been suggestions that many families not only neglect their elders but that they subject them to physical assault. In 1977 a number of newspapers carried stories and articles about 'granny-bashing' and it appeared to the public

that there had been a sudden epidemic of physical assaults. It is true that a small number of old people are assaulted by their relatives but this has probably always happened What occurred in 1977 was not so much an increase in 'granny-bashing' as an increase in public awareness of 'granny-bashing'; indeed David Ennals, then Secretary of State for Social Services, stated firmly in the House of Commons that there was no evidence that physical abuse of old people was increasing.

Small numbers of elderly people are neglected or abused by their families but they are only a small minority; for the majority of old people families provide the principal source of support and the 1971 Census showed how many old people lived with their children. These figures are illuminating, the most striking being

Table 1 Types of household in which elderly people live

	Men (percentage)		*Women (percentage)*	
	65–74	*Over 75*	*65–74*	*Over 75*
Living alone	11 1	27 8	19 1	42 7
Living with spouse	64 1	43 7	54 0	22 7
Living with unmarried child or children	2 6	6 9	5 8	11 6
Living with spouse and unmarried child or children	15 1	11 1	12.2	9 0
Other household types	7 1	10 5	8 9	14 0
Total	100 00	100 00	100 00	100 00

Source • *Profiles of the Elderly*, vol. 1 (Age Concern, 1977).

the high proportion of elderly people who live with their unmarried children, nearly one-fifth of all elders. A different pattern is observed if the marital status of elderly people is considered rather than their age. Five per cent of elderly married couples live with married children and 23 per cent of widowed elders live with married children, usually with daughters Twenty-two per cent of married couples and 23 per cent of widowed elders live with unmarried children.

It could be argued that the fact that a significant proportion of elderly people live with their children does not necessarily mean they are all well cared for, and this point has to be conceded. There

are a small number of people who reluctantly offer accommodation to their elderly parents and who may refuse to accept them back should they be admitted to hospital, but this is only a very small minority. Most children care for their parents lovingly and competently, often at a considerable price to their own health and well-being.

The problems posed by physical and mental disability can be daunting. An elder who is unable to wash or dress independently, and therefore depends upon the help of those with whom he or she lives, places a constraint on their lives. They have to consider the elder's needs whenever they make plans for themselves. If, for example, they are invited to stay with friends in the country they have to arrange for their elder to be adequately cared for in their absence. For most families, however, such a responsibility is no more than a minor inconvenience and relatives can usually cope with physical disabilities provided that the elderly person is neither incontinent nor mentally disturbed.

Incontinence places a major burden not only on the elder (see page 168), but on his or her supporters because of the washing entailed, the smell, and the risk of damage to carpets and chairs. Certain patterns of behaviour resulting from mental disorder are also particularly upsetting. Aggression towards other members of the family, dirty eating habits, and sexual exhibitionism are obvious sources of anguish or anger, but behaviour patterns which interfere with the supporters' sleep may be equally upsetting. An old person going to the toilet is an unremarkable event but if he goes six or seven times every night, putting on the landing light and flushing the toilet on each visit, he may seriously disrupt the sleep of others in the same dwelling. In the same way an old man who is careless about his use of an ashtray and occasionally burns holes in a rug placed under his chair to protect the carpet may cause no more than annoyance during the day but if he wakes up and starts smoking at night the reaction may be one of alarm and when people are deprived of sleep they can quickly become unable to tolerate behaviour which was previously tolerable. The social life of relatives often becomes affected. Some are unable to go away, while others cannot even go out for an evening – baby-sitters are easy to

find but elder-sitters are few in number. Those who live in a small dwelling sometimes feel reluctant to invite friends to visit, believing that they, and their friends, will be embarrassed by the old person's behaviour or attempts to join in the conversation. This particularly affects young people and although grandparents often have a better relationship with young people in adolescence than do their parents adolescent problems can be aggravated by the presence of a disabled elder in the same dwelling.

One group of supporters whose problems merit special consideration are those single daughters and sons who care for elderly parents. The presence of an older person may affect the social and sexual relationship of a married couple but the marriage partners are usually a source of strength to one another and provide both consolation and company for one another when the elder eventually dies The single child, on the other hand, has no other person from whom to obtain support or relief and is often desolate when the elder dies, as a report on bereavement and associated depression issued by the National Council for the Single Woman and her Dependants made clear. The majority of these single children are female, and the burden often falls on the youngest unmarried daughter. The usual pattern of events is for the onset of illness or severe disability of one or both parents to lead to pressure being applied on one, usually the youngest single female, member of the family by other members who are older and married, and by professionals, such as the elder's doctor, to give up work because the elder 'shouldn't be left alone'. In some cases considerable pressure amounting to moral blackmail is applied; in others, one child is willing to go back home to care. Many of these single sons and daughters – it is estimated that there are 310,000 single daughters – find the experience rewarding and fulfilling, but others find it a burden, regret the decision, and then love for the parent may turn, in part, to hostility. Even some of those who accepted it willingly in the first place, perhaps as a way out of a boring job with no prospects, come to feel trapped. The practical problems of single sons and daughters are often severe. More than 70,000 of the 310,000 single daughters care full time and their problems have only been partially alleviated by the Invalid Care Allowance (see page 85).

For example, housing can be lost on the death of the parent. Most local authorities consider sympathetically the plight of a single daughter who is left in their property after the death of an elderly tenant, although the daughter may be asked to move to a bed-sitting room whereas widows are allowed to continue living in the two- or three-bedroomed dwellings in which they lived before the tenant died. Tenants of privately rented property may find themselves homeless if the elder was the legal tenant as may someone who lives in a house which was owned by the elder if the elder's will was not carefully worded. The National Council for the Single Woman and her Dependants, the pressure group acting on their behalf, has taken a special interest in the problems of single children caring for elderly parents, realizing that the attitudes of children, whether single or married, towards their parents are very much influenced by the practical problems they have to face.

Is the family dying?

In addition to stating that 'families don't care' it is also commonly declared that families care less well now than they did in the past – that the family is dying. Before considering whether or not this statement is true it is necessary to list a number of ways in which the family has changed over the course of time. Some of these changes influence the ability of children to care for their parents, no matter how willing they might be.

1. The size of the average family has decreased. Those who married in 1860 gave birth to an average of seven children, but it is probable that those who married in 1970 or in 1980 will have no more than two children each (the definite figure will not be known until they reach the end of their child-bearing years so the figure of two is an estimate).
2. The proportion of women who marry has grown steadily and as much of the care of elderly people has been, and is, provided by single daughters this trend has reduced the numbers of those who are able to devote their attention solely to elderly relatives. In 1901 there were thirteen spinsters for every hundred old people; in 1978 there were only five per hundred.

3. Those women who marry do so earlier. In 1870 the age at which women married was, on average, 27; in 1970 it was 22½.
4. An increasing percentage of married women work. In 1921 only 8 7 per cent of married women worked, in 1976 the percentage was 44.3.
5. Population mobility is steadily accelerating, with sons and daughters moving away from their parents. Nearly one household in ten moves every year, half of whom move a considerable distance

In spite of these trends, all of which reduce the opportunities for children to care for elderly parents, the evidence is unequivocal that family support for elderly people is at least as good as it has ever been. The proportion of people in long-term residential care is only half what it was in 1911.

On the evidence of these figures it neither seems to be the case that families care less than they did nor that the introduction of the welfare state has significantly reduced the family's willingness to care. It is true that some of the relatives of elderly people adopt the attitude that the warden of the sheltered housing or the staff of the old people's homes in which their elder lives should provide *all* the care that is required but they are only a minority. Some of those who take this view feel bitter about the amount of rates and taxes that they pay; some are envious of the secure jobs and good pensions of local authority and health service employees; and others simply do not feel any personal loyalty and affection towards the elder requiring care. Before condemning children who refuse to care for their parent it is important to remember that not all old people are nice old people and that some were not caring and loving parents when they and their children were younger.

On the available evidence it seems that the growth of the welfare state during this century has not destroyed the family. On the contrary it can be argued that it has supported and strengthened family ties by reducing the burden imposed on families by the problems of old people. In 1860 families looking after elderly people had to provide all the financial, physical, and social support with little or no assistance while simultaneously having large numbers of children, often in poor housing and poverty.

Indeed it is the experience of many professionals who work with families that families which declare that they are unable to continue caring for their elder do so more often because of deficiencies in the provision of welfare services than because of surplus. The help they are offered is too often too little and too late.

The belief that families no longer care is by no means new. In the 1920s one prominent authority wrote: 'The Family is virtually non-existent nowadays in contradistinction to the medieval family, or even that of a century ago'. The Royal Commission on the Poor Laws (see page 22) stated in 1909 that there was a 'disinclination of relatives to assist one another', and that 'there is not the same disposition to assist one another that there was years ago' and the Report of the Royal Commission on the Poor Laws of 1832 made the uncompromising assertion that 'the duty of supporting parents and children in old age or infirmity is so strongly enforced by our natural feelings that it is well performed, even among savages, and almost always so in a nation deserving the name of civilised We believe that England is the only European country in which it is neglected.' There is now a wealth of evidence to prove that this long-standing belief is wrong. A number of studies have shown how much help is given by families to their elders, notably that organized in Glasgow by Bernard Isaacs, now Professor of Geriatric Medicine in Birmingham, which he called *Survival of the Unfittest.* Peter Townsend also reported in his classic study *The Family Life of Old People* that he found old people getting a great deal of help, regularly and in emergencies, from their relatives, particularly their daughters living in neighbouring streets; and many other research workers have found that families are often the main pillar of care and support. Not only has evidence emerged to show how supportive families are in present times, but certain historians, called social historians because they are interested in topics such as family size and structure rather than in politics and war, have shown that the belief that all families cared for their elderly in the past was a myth. The contribution of the family in the twentieth century has been clearly demonstrated by Robert Moroney of the University of North Carolina in research sponsored by the Joseph Rowntree Memorial Trust, and published in a

short, but excellent, book called *The Family and the State*. Moroney's research was based on official government papers but knowledge about the personal relationship between the family and elderly people in earlier times is much more difficult to determine. It was not until 1838 that registration of births and deaths was introduced by Act of Parliament so that even such elementary details as the average family size in the eighteenth century is not known with certainty. Peter Laslett, a Cambridge historian, has, by painstaking research in parish registers and other scattered sources of information, pieced together an amazingly clear picture of family life in olden times. In a series of brilliant books and articles he has argued that there was no Golden Age before the Industrial Revolution and that 'it is wrong to suppose that in traditional England provision was made for the physical, emotional or economic needs of aged persons, aged relations, or aged parents in a way which was in any way superior to the provisions being made by the children, the relatives and the friends of aged persons in our own day'.

Images

Elderly people receive a surprisingly large amount of coverage in the press. The newspapers, of course, frequently record the age of people in the news even though their age is not in the range which is usually considered to be elderly, for example 'Mrs Jones (37) of Swansea, trapped for three hours . . .', but when the person is over pension age the age is almost always given, frequently in headlines. One-hundredth bithdays and golden weddings are rightly given prominence because they are still rare events, but old people are also reported if they act in a way which does not conform to the passive, unintelligent, unadventurous, asexual image of old age. It provides a 'human interest' story if an old person acts like a young person. 'Granny, 72, Leads Anti-pong Fight', 'Casanova of 75 Dated New Lady Friend Every Week', 'B A. for Woman Aged 81', 'Fan-dancer Gingers Up the Old Folk'.

The other type of a story carried by the press is the campaign story. The paper either exposes a case which has been neglected by the health and social services, or a cause which should be taken up

by its readers. The appeal may be for direct actions by the readers – 'Come On, Now – Help the Old 'uns to Have a Knees-up' – or for political action. This style of campaigning journalism is in keeping with the traditional role of the press and such campaigns can be influential although few papers maintain sustained campaigns for long periods of time. Consider the problem of hypothermia. Old people have died of hypothermia since earliest times but it was not until the 1960s that the press began to take notice of the problem, stimulated by research findings and the pressure group Help the Aged. The emphasis was initially on individual cases, reported under headlines such as 'What Went Wrong?', but some journalists probed more deeply and a team of journalists from the *Sheffield Star* won their editor the IPC award for the Campaigning Journalist of the Year in 1970 for their investigation into the plight of elderly people. The press became interested once more after the OPEC increase in oil prices in 1974 made 'energy' stories popular. In 1976 major press coverage was again given to the heating problems of pensioners but in the winter of 1977, which was equally cold and in which there were almost certainly just as many cases of hypothermia, this problem received little coverage.

Elderly people rarely appear in advertisements. One reason for this is that they have an unattractive image. Advertisers wish to create an attractive image for their products and usually do this by associating the name of the product with images which are known to be attractive; these are almost always youthful and good-looking. Another reason is that advertisers are rarely aiming their message at elderly people, so they do not feel there is any need to include an image with which an elderly person can identify; most elderly people have too little disposable income to interest advertisers Of 100 people appearing in television advertisements at peak viewing times only 4 were elderly. Two were included to attract the interest of elderly viewers, one a grandmother visiting the Birmingham Bullring with her family, the other a white-haired man in a group of drinkers downing Younger's Tartan. The third was a lady dressed up in a nineteenth-century cap and apron demonstrating the delights of Kraft processed cheese spread to her grandson; this old person was included not because old age is

attractive but as a symbol of the 'good old days', of simple and wholesome food. (An old man is used for the 'voice-over' in Hovis advertisements for the same reasons.) The fourth to appear was a crotchety elderly man sitting in the back of a new-style Rover. The advertiser's objective was obviously to change the image of the Rover, traditionally an old man's car, by showing an old man obviously out of place in the new model.

On television and radio the image presented usually conforms to the stereotype. Albert Tatlock, grumbling and harping about the past, fairly easily quietened and placated by a pint; Ena Sharples, high principled but intolerant; and Walter Gabriel, a bit of a bore, albeit amusing and likeable like Gabby Hayes, are three of the best-known elderly characters but the image they present is rather depressing.

There are many other images of old age, in the Bible, Shakespeare, and popular song, to give only three examples, and it is important for anyone interested in older people to be alert to such images and aware of their significance. Such images are of great importance because they both symbolize and perpetuate public attitudes to old age and influence the attitudes of old people themselves.

5 Their attitudes

Towards growing old

So far we have considered the attitudes of other people towards old age and old people but the attitudes of old people themselves must not be forgotten.

First let us consider their attitudes towards the social process of growing old. As we have stated previously (page 0), growing old is an artefact of society, as distinct from the natural, biological process of ageing; society creates the rules by which old age is defined. Growing old has many stages of which the two most important are retirement and the onset of disability.

In the investigation of elderly people at home carried out by the Office of Population Censuses and Surveys, those who were visited

Table 2 Suggested ways in which elderly people could be helped

	Men (*percentage*)	*Women* (*percentage*)
Increase old age pensions	13 2	5 4
Provide free or cheap phone calls	7.9	7.9
Help with fuel bills	11.5	9 2
Voluntary helpers to assist with tasks	5 6	7 6
Voluntary helpers to provide company	10.1	11 8
Regular medical or welfare visits	10 8	10 9
Suitable housing	4 3	4 8
Better public transport	3 2	3 2
No suggestions	36 5	43.3

Source: The Elderly At Home (*H.M S.O.*, 1978).

were asked how they thought elderly people could be helped. What is striking is that a large percentage of elderly people made no suggestion and other surveys have found that many elders appear to be satisfied with their lot. When asked to indicate their degree of satisfaction with their housing conditions on a scale ranged from 0

(complete dissatisfaction) to 10 (complete satisfaction) people over 60 gave an average score of 8.5 compared with the 7.4 rating of younger people, in spite of the fact that their housing conditions were less adequate (see page 90). Elderly people gave a satisfaction score of 8.1 for their standard of living compared with 7.3 for younger people, although they owned fewer consumer goods (page 77). Similarly, elderly people gave a score of 8.4 for their satisfaction with leisure facilities compared with 7.1 for younger people, although the range of outside activities of elderly people and their ability to visit friends and relatives were very limited (see page 104). Only with respect to their health were older people less satisfied. It is, however, important to emphasize that such averages mask the wide range of levels of satisfaction in both age groups. The survey, organized by Dr Mark Abrams and published in volume 1 of Age Concern's *Profiles of the Elderly*, revealed that one-fifth of elderly people expressed very low levels of satisfaction with all aspects of their lives. Those who were dissatisfied were not unhappy simply because they were the type of people who had always grumbled and felt dissatisfied; it was clear that many had experienced a rapid decrease in their levels of satisfaction in old age. As many of these were women, living alone and in poor health, it could be argued that the impact of bereavement and the onset of disability were two of the factors which were most responsible for a loss of satisfaction. This substantial minority of dissatisfied elderly people are, by and large, a silent minority. Many are housebound and few have access to influential media or the confidence to express their frustration and dissatisfaction in writing but they have their eloquent advocates. In America Robert Butler pleads their case in *Why Survive? – Growing Old in America!*, published in 1971; in Britain Peter Townsend and Dorothy Wedderburn's book *The Aged in the Welfare State*, published in 1965, is less emotional but equally cogent yet the most moving account of the attitudes of old people are those given by themselves. Georges Simenon's account of the feelings of uselessness he experienced at the age of 60 in *When I Was Old*, feelings which he overcame, is well worth reading but even more impressive is Gladys Elder's remarkable book *The Alienated – Growing Old To-day* Brought up in poverty, Gladys Elder wrote

her book near the end of an arduous life. She opens her attack on contemporary society's treatment of old people with a quotation from Franz Kafka's *Metamorphosis*, the story of a man who turns into a giant beetle.

As Gregor Samsa awoke one morning from uneasy dreams he found himself transformed in his bed into a gigantic insect. He was lying on his hard, as if it were armour-plated, back and when he lifted his head a little he could see his dome-like brown belly divided into stiff arched segments on top of which the bed-quilt could hardly keep in position and was about to slide off completely. His numerous legs, which were pitifully thin compared to the rest of his bulk, waved helplessly before his eyes.

What has happened to me?, he thought.

Those who knew Gregor were horrified and repelled by his new appearance; he had become an alien in familiar territory. To Gladys Elder the process of becoming old is a metamorphosis, people are forced to retire and are then alienated from the society they helped to create. This is a powerful analogy which undoubtedly expresses the feelings of many elders, although few, perhaps, feel it as strongly as Gladys Elder did.

Any assessment of the attitudes of old people to their present social status, whether elicited by social surveys or freely expressed in writing, has, however, to take several factors into account because the accuracy of the answers given to those who conduct social surveys of the sort used to measure life satisfaction must be questioned. There can be few people who have not been guarded in their answers to, or have even misled, market researchers enquiring which toothpaste we use or which papers we read, and elderly people must be equally, or even more, suspicious of such interviews. Consider what might pass through the mind of an elderly person asked how satisfied she is with her life. She may ask herself to what use this information will be put, and the researcher's reassurance that it will not be revealed may be treated with caution; many elderly people know from bitter experience just how much personal information is transferred from one professional to another. If the elder were to admit she is not satisfied might not someone try to persuade her to go into a home? If she says she is satisfied might not someone decrease the amount of help

she is currently receiving? These questions are crudely expressed but such attitudes towards surveys of satisfaction must not be discounted. It is probable that surveys of the type quoted underestimate the extent of unhappiness, not only because people fear that they may be encouraged to enter a home if they say they are dissatisfied but also because some people are unwilling to expose the painful areas of their lives to strangers. Some may even be unwilling to admit their feelings of rejection and dejection to themselves, finding it less painful to believe that they are satisfied with life. In addition to these problems, which are taken into account by those who carry out social surveys, the attitudes of old people have been moulded by the biography of their generation which greatly influences their expectations of what they want and what they demand from society.

The elderly people who receive most help are those over the age of 75, although many over this age are fit and well. This generation was born at the end of Victoria's reign or in the Edwardian era. Although the impression of that age is one of golden prosperity only a small proportion, no more than 5 per cent of the population, lived in the prosperity described by Galsworthy and Bennett. Many children were malnourished. A government survey in 1905 found that 31 per cent of Manchester children were badly nourished and the position in other large cities was similar, if not worse. Many of the little old people of today are not of low stature because they have shrunk due to ageing but because they were malnourished as children seventy or eighty years ago. In spite of the grindingly hard conditions under which many people lived there was an air of confidence in some sections of society. The novels of H. G. Wells portray his confidence; even when his heroes Kipps and Mr Polly are failing financially there is a feeling that things will turn out well. V. S. Pritchett's autobiography *A Cab at the Door* describes his Edwardian childhood and gives a wonderful account of this confidence. The cab was often at the door, eighteen times by the time Pritchett was 12, because his father was frequently bankrupt and forced to flee his creditors, yet he remained blithely confident most of the time. It is wrong to assume that Victorian and Edwardian times were uniformly serene and confident. The voice

of dissent was growing but the existing social order was not seriously questioned. Robert Tressell's allegorical description of the humiliating and brutalizing effects of poverty and unemployment, *The Ragged Trousered Philanthropists*, which has been a turning-point in the lives of many socialists, portrays the other, larger, side of Edwardian life and the growing tensions within society. This mounting internal tension was resolved, partially at least, by the external threat provided by the First World War. This was the case in France and Germany as well as Britain and men volunteered in large numbers, confident that 'it will all be over by Christmas'; women encouraged them, confident that they would soon return The reality was very different. The famous war books such as Robert Graves's *Goodbye To All That*, Siegfried Sassoon's *Memoirs of an Infantry Officer*, and the German Erich Maria Remarque's moving classic *All Quiet on the Western Front* are all well known. Other, less famous books help paint a picture of the numbing, pitiless violence which appeared, to the man in the front-line at least, useless and senseless. *The Middle Parts of Fortune* by Frederick Manning, *The Ebb and Flow of Battle* and *In the Cannon's Mouth* by P. J. Campbell, and Martin Middlebrook's brilliant and dramatic reconstruction of *The First Day on the Somme* should all be read by anyone interested in elderly people – or interested in himself, for their biography is part of our biography – as should Paul Fussell's brilliant book, *The Great War and Modern Memory*. The effect of the Great War on the nations which took part has been likened by one writer to the effects of the Black Death; a whole generation was gravely wounded and disabled. The scale of the tragedy was best described by Winston Churchill whose history of the First World War was published in 1923.

> A young army, but the finest we have ever marshalled; improvised at the sound of the cannonade, every man a volunteer, inspired not only by love of country but by a widespread conviction that human freedom was challenged by military and Imperial tyranny, they grudged no sacrifice however unfruitful and shrank from no ordeal however destructive. Struggling forward through the mire and filth of the trenches, across the corpse-strewn field amid the flaring, crashing, blasting barrages and murderous machine-gun fire, conscious of their race, proud of their cause, they seized the most formidable soldiery in Europe by the throat, slew them and hurled

them unceasingly backwards. . . . The flower of the generous manho which quitted peaceful civilian life in every kind of workaday occupatic which came at the call of Britain and as we may still hope, at the call humanity, and came from the most remote parts of her Empire, was sho away for ever in 1916.
('1911–1918. The World Crisis', vol. i, p. 750)

Men returned from 'The War to End All Wars' to 'Homes I For Heroes' which had not been built, and to jobs which h vanished or been taken by those who had stayed at home or l women: the impact of the war on the place of women in society often underestimated. Years of unemployment followed years fighting. Then came the confrontation and humiliation of t divisive General Strike. The reasons why there was not a revoluti in Britain remain a matter of debate but one reason was that t spirit of the generation had been largely extinguished by th experiences in the war. As Erich Maria Remarque wrote in *Quiet on the Western Front*:

Had we returned home in 1916, out of the suffering and the strength of o experiences we might have unleashed a storm. Now if we go back we will weary, broken, burnt out, rootless, and without hope. We will not be al to find our way any more.

The thirties were another hard decade and were followed by t Second World War in which many of those who had fought made sacrifices in 'The War to End All Wars' lost their childre their possessions, and their lives Finally came retirement in t late forties and fifties: retirement into poverty on a pension whi was much lower, in real values, than the pension today.

That old people are more satisfied than young people, ev though the latter are in better conditions, can be understood in t context of this biography, as they have been brought up in mu worse conditions than those in which the majority of young peop were brought up. Many are accustomed to cold houses, cold wat outside toilets, and poverty and compare their present situati with a past which was much worse.

Mr S was an 82-year-old Old Contemptible, and very proud of it. Disabl by bronchitis and a stroke he lived in two downstairs rooms of his coun house His bedroom was so cold and damp that his bedclothes were p manently wet from condensation His health visitor had managed to ra

half the money for a gas fire for his bedroom from his regiment's welfare fund but was having difficulty raising the other half from either social security or social services, who were disputing who should pay. As she apologized to him a third time about the delay he smiled and reassured her saying, 'Don't worry, I can manage without a fire. Sixty years ago today I was up to my waist in mud and water.'

Another reason why elderly people are satisfied with poor conditions is that their attitudes are different. Young people who have never had to live through hard times base their expectations on the assumption that things could be better than they are. Elderly people, on the other hand, often view their position on the supposition that things could be worse. People of all ages only want what they believe to be within the bounds of possibility: we may dream of great wealth or power occasionally but to do so any more frequently leads to depression. Old people have had so many disappointments that many have a very limited view of what they may possibly hope for and aspire to. Their biography also limits their demands People of all ages demand what they want, and what they believe to be their right. A man may want four pints of Newcastle Brown Ale daily but he knows he has to buy them; he cannot demand them of society as it is not a right to drink four pints of Newcastle Brown Ale daily. However, the same man may demand shelter for his family and a fair wage for his work; these are his rights Our elders have a much more limited view of their rights; young people frequently contest the decisions of authority while their elders usually accept such decisions without recourse to the courts or the press or the Supplementary Benefits Appeals Tribunals. Those who are elderly today have been brought up in an era in which common men and women had much less power than they have now. They have a circumscribed view of their rights and hesitate to make demands on society. This is already changing as those who are joining the ranks of retired people now have experience of the power of groups of people who band themselves together in unions or professional associations. This trend will increase (see page 247) but those who are very elderly at present will probably continue to be satisfied with their lot.

Is this high level of satisfaction of the majority a matter on which

our society can congratulate itself or should we be concerned that they are not more dissatisfied and demanding? George Bernard Shaw wrote that 'satisfaction is death; when I cease to want I cease to live'. This is an extreme view but one worth consideration; perhaps we should be trying to encourage old people to think that 'things could be better' instead of accepting their situation on the grounds that 'things could be worse'. Against such a revolutionary approach can be set the argument that encouraging elderly people to think that their lot could be improved would in many cases lead to disappointment and frustration and that the elders would be left with those feelings without having achieved any amelioration of their situation. This is true. Peace of mind can be destroyed by stimulating people to desire something which proves to be unattainable but it may be that elderly people are not stimulated and disappointed enough. In part this is due to the ageist belief of many young people that their elders are unable and unwilling to change but it is also based on the idea that it is kinder to old people not to disappoint them. Disappointment and frustration are part of the everyday experience of young people; they not only help to stimulate social change but are of benefit to the individual whose mind is stimulated. Although elderly people have a right to set their own standards there is little to suggest that they are different from young people, that they would not enjoy better living conditions and a higher income if it were possible to attain them, or that they should not be encouraged to strive for a better deal from society.

Other biographies

Although there are some similarities between the elderly people in different cultures the biography of each is distinctive. What we have described is the biography of the generation of people born and raised in Britain in late Victorian and Edwardian times. Those who were born later have a different biography and different attitudes as is demonstrated by the more militant style of pensioner campaigning which developed in the seventies, organized by retired trade union members (see page 247). Biographies not only differ from one generation to another, they differ from one

part of the country to another. The biography, and therefore the attitudes, of elderly people in a South Wales mining community are very different from the biography and attitudes of those in farming communities in Mid Wales or Gloucestershire and – an increasingly important feature of professional and voluntary work with elderly people – the biographies of elders who were born and raised in Commonwealth countries but who are now growing old in Britain bear little resemblance to the biography described in detail here. People who grew up in India and Pakistan or on one of the islands in the Caribbean do not share the same set of expectations as British-born elders. They interpret their needs and express their wants and demands in their own ways, which are frequently misunderstood by professionals familiar only with British culture and biographies. The biographies also vary from one social class to another and the early chapters of the biographies of elderly men and elderly women in this country share only some features. The experience of women has, until recently, been seriously undervalued and ignored.

Of course biographies which relate to groups are all generalizations which are potentially misleading. What is important is the biography of the individual. We tend to think of biography in terms of famous men and women but the biography of every individual is important not only to understand that person's attitudes and values but to illuminate our understanding of the society in which we live. This has now been recognized and accepted by some historians who practise what is called oral history – the collection of the memories of men and women from all strata in society with the aid of tape recorders Paul Thompson's book *The Voice of the Past* is an excellent introduction to this subject and emphasizes the importance of oral history not only as a means of learning about the past but as a means of understanding the present – our present.

Towards ageing

Attitudes of old people towards the effects of the ageing process itself can be considered under two headings – attitudes towards the

change in appearance which inevitably results from ageing of the skin and attitudes towards disability which may result from one of the diseases which occur in old age. For many people the change in their appearance is the first serious intimation of ageing. It matters relatively little to most women if they become a little more breathless on exertion as they age but grey hair or facial wrinkles prompt them to determined, and often expensive, action. For men the change of appearance is less of a problem Some older men appear to be equally as attractive to the opposite sex as young men, provided they can avoid obesity, and the numbers of men in their forties, fifties, and sixties who marry young and attractive women are legion. The marriage of older women to young men, on the other hand, is rarer and evokes feelings of distaste in some people, feelings similar to those about sexual activity in old age.

To most people disability and old age are so closely interrelated that the former is seen as the inevitable result of the latter. Some loss of ability is indeed inevitable. No man can expect to climb Snowdon as fast, or by the same difficult routes, at 70 as he was able to manage when he was 20. To expect this is unrealistic and a recipe for frustration and depression. This does not mean, however, that no man can expect to climb Snowdon at 70; many do, though taking easier routes and rather longer than they did in their youth. What is required, but what is difficult for many elderly people and their advisers to achieve, is to strike the right balance between trying to do more than one is able, which may result in failure, frustration, and depression, and not trying to perform tasks of which one is capable because of the expectation of failure; this may also result in frustration and depression Many elderly people do manage to strike a good balance; sometimes biting off more than they can chew, on other occasions not attempting what they could easily achieve, but mostly leading a full and active life within the inevitable restrictions which occur in old age. If anything, however, the balance is too much towards under-achievement: too many elderly people accept the depressing image of old age too readily and come to believe that they are less able than they actually are. This is not surprising. It is not unknown for doctors to say to elderly people who complain of disability, 'What do you

expect at your age?', a question which easily becomes the old person's resigned complaint 'What can you expect at my age?' Thus the ageist attitudes of young people become the negative, over-cautious attitudes of their elders.

There is of course a whole range of attitudes towards old age among elderly people which our generalizations mask. To some growing old and ageing are matters of little concern; to some indeed they are a source of pride. Those who feel that their appearance or activities belie their age, and those who feel they are ageing 'better' may consider themselves in competition with other people of their age. Guy de Maupassant's famous short story 'An Old Man' tells of Monsieur Daron who goes to live in a spa town, Rondelis, but stays there only on condition that the doctor in charge informs him of the names of all those over the age of 80 so that he can try to outlive them all. Professional or voluntary workers who meet elderly people regularly are often asked to guess an individual's age. One is tempted to guess the individual's age then subtract five or ten years to flatter and encourage the elder, which of course reinforces the elder's idea that she is young for her age and stimulates her to ask her next visitor the same question.

Not all old people have such a happy attitude to the effects of ageing. The onset of disability is of particular significance because the elder is transformed from an active, independent person to one who is inactive and dependent. J. B. Priestley, when aged, wrote a savage indictment of old age in *Instead of the Trees*, a volume of autobiography:

> Why not a piece, as honest as I can make it on Old Age? A lot of people have told us how they are enjoying – or have enjoyed – their old age. I am not one of these complacent ancients. I detest being old. I can't settle down to make the most of it – whatever that may be – but resent almost every aspect of it. . . . Because I am old, almost everything demands both effort and patience. Nothing runs itself. What – even getting dressed or going to bed? Certainly. They are both workouts. I do not say tremendous efforts are involved, but there are no easy routines here, nothing accomplished while thinking about something else. I can have a little wrestling match just getting into a pair of trousers Just coping with the mere arrangements of ordinary living, there must continually be an exercise of will To get by from nine in the morning until midnight I use enough willpower to command an army corps

Disability can be very depressing, as can incontinence (see page 168), not just because of the discomfort and pain but because of the dependence on others which results (page 108). Thoughts of suicide are common (page 114) as not only does the elder have to face the consequences of the present level of disability, but the fear of the uncertain future has also to be coped with, fear of further physical degeneration or – what frightens many people to a greater extent – mental deterioration. Sir John Masterman wrote of this fear shortly before his death:

> At 85 I myself, in spite of physical deterioration, am happy and content, but there is one black cloud on my mental horizon. It is the fear that the brain may disintegrate more quickly than the body, and that I may fall into that lamentable state when I can no longer communicate with my fellows, no longer enjoy any part of life, no longer even be able to beg that I may be allowed to 'depart in peace' – in fact a human vegetable, equally a burden to himself and others.

Lord Moran's biography of Churchill, *Struggle for Survival*, provides one of the most detailed studies of a man growing old and ageing and his reactions to these changes. Winston Churchill was 65 in the spring of 1940, retirement age, and his performance over the next five years provides one of the strongest arguments against compulsory retirement. It was not until Churchill was 70 that Moran, or Sir Charles Wilson as he was at that time, began to note signs of ageing. In December 1947 he records 'Winston living in the past and impatient of change . . . sliding imperceptibly into old age'. He developed a hernia and he seems to look on it as 'a particularly humiliating hint . . . of the impermanence of things The very integument which confines his vital organs has, he protests, given way: it can, of course, be patched, stitched and strengthened to hold for a little longer, but only for a time.' In 1949 he had a stroke; to Sir Charles it was only a minor stroke as Churchill had not been paralysed: only his power of sensation had been affected! Sensation doesn't matter, Sir Charles Wilson told him; Winston replied sharply, 'life is sensation; sensation is life'. In 1952 an even more serious sign developed. Churchill, a consummate master of the English language, was unable to summon the words he desired while speaking on the phone. He was Prime Minister at the time

but there was evidence that he was unable to master his work as well as he had done formerly; five-page documents had to be compressed to a single paragraph. His supporters considered encouraging him to retire, to go to the Lords while remaining Prime Minister, but it was decided that it would be impossible to persuade him to agree. He rallied again and wrote to Sir Charles Wilson, who was trying to persuade him to ease off, 'I don't want you to worry. You really needn't. One has got to die sometime.' By December 1953 he was once more finding it difficult to cope with the demands of office. At the Bermuda Conference he lamented, 'Dulles is a terrible handicap; ten years ago I could have dealt with him. Even as it is I have not been defeated by this bastard. I have been humiliated by my own decay. Ah, no, Charles [Wilson] you have done all that could be done to slow things down', at which point he started to cry. Once more he rallied but refused to consider retirement, saying on 16 December 1954, 'I think I shall die quickly once I retire. There would be no purpose in living when there is nothing to do. I don't mind dying.' When he finally retired the effect was profound, he felt he 'was breaking up quickly', that 'there is nothing to do except to die'. From this time on 'Winston's Black Dog', his moods of depression, returned with increasing frequency even though Wilson omitted 'the painful details of the state of apathy and indifference into which he sank after his resignation'. Affected by ageing, suffering from the disease which resulted from his long, arduous, and, in certain respects, excessive life-style, and eventually rendered relatively useless by his enforced retirement the last twenty years of Churchill's life were a series of stern challenges. His response to these challenges was typically courageous but even he was bowed by their weight.

6 The social life of our elders

The family life of old people

As marriage partners

For most people in this country the family is the main influence in their social life and for the majority of adults their marriage is the focus of family life. Each partner in a marriage both gains and loses; certain characteristics of personality are accentuated, others are inhibited. Each partner remained recognizable as an individual but also becomes known as one of a couple and the couple takes on a personality of its own and a strength of its own. Elderly married couples rarely require admission to residential care for the strengths of the one often complement the weaknesses of the other – for example, a blind husband and a deaf wife are able to use their skills in combination – but the strength of a married couple is more than the total of the identifiable physical abilities of the members of the couple. Elderly couples also support each other psychologically and of course avoid the dreadful consequences of isolation (see page 102), although one or both may still be lonely, and this psychological strength helps many couples to cope even though both members are severely physically disabled.

Because men die earlier than women, on average, the proportion of men who are married is higher than the proportion of women, 75 per cent compared with 38 per cent, and this difference is greater the older the age group considered. Among people aged over 75 the proportions who are married are 59 per cent of men and 18 per cent of women.

The loss of one's spouse is a tragic event at all ages but in old age its effects are particularly severe No sharp demarcation line can be drawn between marriage partners as can be drawn between two

acquaintances; their personalities blend. Each retains certain individual characteristics but they also have a common personality and each becomes a part of the other. The death of a spouse therefore is not only a loss of someone else but a loss of part of oneself, part of one's spirit is abruptly sheared off by bereavement, as a limb may be torn traumatically from the body by a passing train. After thirty or forty years of marriage the loss is very great and it comes at the stage at which it is less easy to adapt, not so much because older people are unable to adapt but because they are more likely to live alone without people to whom they can easily turn for support, and to be immobilized by disability and the lack of a car (page 105).

Bereavement has serious practical consequences. The wife loses her gardener, handyman, and accountant. The husband loses his homemaker, cook, and valet, and the fact that scurvy is sometimes called 'the widower's disease' indicates how severe the loss of a wife may be to a man accustomed to a life in which it was considered proper for men to work long and hard out of the house and for women to do everything in the home. Not infrequently emergency admissions to old people's homes or hospitals are necessitated by the sudden death of an elder who had previously been the principal source of support for a disabled spouse, because death exposes the survivor's weaknesses.

More grave than the practical consequences are the psychological. It is inappropriate to think of 'getting over' the loss of a husband or wife, although the phrase is in common use, and more accurate to think of learning to live with the loss, as a disabled person learns to live with one leg or with blindness. Techniques are developed by which the effects of the loss are minimized but these take time to learn and the early period after bereavement is a time of grief. The components of grief vary from one person to another. Apathy, anxiety, despair, depression, agitation, guilt, anger, and resentment are all common and natural. The same individual may experience more than one of these feelings, either simultaneously or in sequence, and a deep feeling of loss, of desolation, is always present whatever other mood is felt. There may be physical effects such as loss of appetite and weight, and it has been suggested that widows and widowers die more frequently than

married or single people of similar age, that is they die of a broken heart. One study of more than 4,000 widowers produced the conclusion that 'Widowerhood appears to bring in its wake a sudden increment in mortality rates of something like forty per cent in the first six months followed by a fall back to the level for married men in general'. These findings have been disputed and several other research projects have failed to show any mortality due to bereavement but the suspicion remains that those who are bereaved, especially men, may die of a broken heart.

The profundity of the grief and the severity of its effects in the early period after death can be mitigated by the process of mourning and by sympathetic support from friends, relatives, and professionals. Many people poke fun at the elaborate mourning rituals which were observed in Victorian Britain, and which are still observed in some societies today. Victoria's long period of retreat dressed in black seems exaggerated today, and evoked some criticism even in her own time, but the prolonged ritual of mourning had a useful function in allowing the bereaved person to change status from wife to widow slowly and perceptibly. Not only could a bereaved person be identified by his or her dress; the mode of behaviour was noticeably different. In the early stages after the bereavement grief could be publicly expressed, often in a dramatic manner, without friends and relatives calling in a doctor with a request that he should sedate the grieving person, although it is often a merciful release for a person who is distraught with grief to be helped to sleep by means of a drug. Grief has its uses, however. The bereaved person today is expected to move quickly and imperceptibly from wife to widow and to make this difficult transition with little show of emotion. Our society is as embarrassed by verbal or visual references to death as previous generations were embarrassed by references to sex. Fortunately, professional and voluntary workers are increasingly open and helpful in bereavement. Doctors and nurses are now better trained and more prepared to work with the clergy to help the bereaved people come to terms with their loss and the activities of CRUSE, the voluntary self-help group, ably supports professional efforts.

It should never be forgotten how many women were prematurely widowed, either in the early years of married life or even before

they were married. Almost one million young British men died in the First World War, and in France and Germany the effect was even more drastic – each nation lost nearly one and a half million young men on the Western Front and two million men over all, leaving millions of women desolate at an age at which young women today look forward to decades of married life.

As parents and in-laws

Although our image of family life in the early years of this century is one in which large numbers of children were the rule, large families were relatively little more common than they are today and many

Table 3 Numbers of children born to elderly people

Number of children	*Born to people aged 65–74 (percentage)*	*Born to people aged over 75 (percentage)*
None	30 4	30.1
1	22 2	22 5
2	24 6	22 4
3	12 9	11 5
4	4.3	5 5
5	2 8	4 3
6	1 4	1.1
7	0 7	1 1
8	0 7	1.4
Total	100 00	100 00

Source · Mark Abrams, 'Beyond Three Score and Ten' (Age Concern, 1978).

elders, almost one-third, are childless. Of those elders in the Age Concern survey who had had children, one in ten had no surviving child, that is they had outlived their children, with the result that 35 per cent of old people, more than a third, have no living children.

The relationship of parent to child changes when the child becomes recognized as an adult, but no matter how old the child may be he or she is still a child to the parents. Parents and their grown-up children behave towards one another as adult to adult but the parent–child relationship persists; in some families more so than in others, even where the parent is in her nineties and the child in her sixties This can create problems for both. The child may be reluctant to correct his parent when she makes a mistake so

that her mistakes go uncorrected (see page 31); he may also find it difficult to correct his parent if her behaviour is reprehensible (page 120) or to encourage her strongly enough to overcome a disability.

The relationship between parents and a grown-up child is changed by his or her marriage because the elders now become 'in-laws' as well as parents. The introduction of another person into the relationship network alters the balance of every relationship in the family; between each parent and the child and between the parents, as well as between the grown-up child and his or her spouse. A great deal has been written in general terms about a mother's hostility towards a daughter-in-law and a father's competition with a son-in-law but such generalizations have to be treated with caution, as do the music-hall jokes about mothers-in-law. Some people have relations with their in-laws that are as good as, if not better than, those they have with their own parents.

As grandparents

The arrival of each grandchild is an important event for an elder as it extends and makes more complex the family network. In a family network of an only child and a child-in-law there are only three relationships:

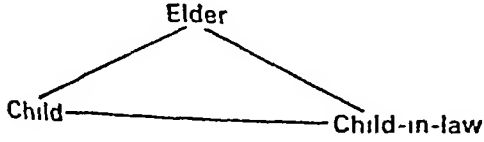

Fig 3

If two grandchildren are born there are ten:

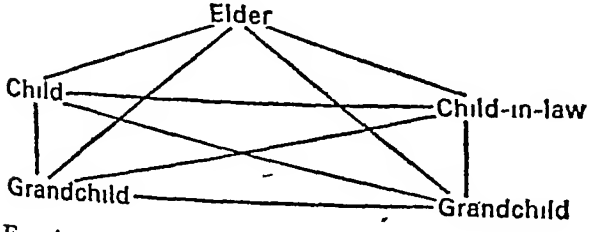

Fig 4

The relationship between grandparent and grandchild often has more affection and less tension than that between parent and child. Most grandparents have a rarity value because they do not usually live in the same dwelling as their grandchildren and they do not have to exercise as much discipline as the parents. This latter feature may disturb the relationship between grandparents and parents and the parents' marital relationship. Some parents believe that their own parents 'spoil' their grandchildren, either by giving money or luxuries usually denied them or by allowing them to waive rules customarily observed, such as the time of going to bed. Even more irritating to parents is a grandparent who spoils a grandchild in certain ways while simultaneously criticizing the parents over other aspects of the child's upbringing, for example by allowing a granddaughter to stay up later than her usual bedtime but criticizing her mother for allowing the girl to go alone to a party 'at her age'. The grandchild may thus be used as a means of criticizing a son or daughter-in-law. In the majority of families, however, grandparents are valuable and valued members, caring for their grandchildren when the parents are at work or visiting friends, although the contribution made by grandparents to child-rearing has been undervalued by many writers on childhood. One book on child-rearing has no index entry for grandparents but three for 'genital play', another, widely considered a 'classic', also ignores grandparents but has four index entries for 'guilt'; and an American book on child development omits grandparents but includes 'Guatemalan children' in its index. A notable exception is Dr Hugh Jolly whose *Book of Child Care* has ten references to grandparents in the index and who gives grandparents encouragement and praise. The importance of grandparents received significant, albeit belated, statutory recognition in 1978 when the House of Commons approved, without a vote, 'the Grandparents' Charter' which resulted from a campaign by the MP for Cambridge, Robert Rhodes Jones, who had realized that many grandparents were barred from seeing their grandchildren. The commonest cause of this is the death of one of the partners in the marriage and the re-marriage of the survivor, because some step-parents feel jealous of and threatened by the relationship between the new

step-children and the parents of their deceased partner. It may also occur as a result of divorce, in which case it is the paternal grandmother who is most commonly affected, because it is more common for wives to be given custody of children. Before the Charter grandparents had to apply to the High Court for wardship, a procedure which was always expensive and often unsuccessful but after the Domestic Proceedings and Magistrates Court Act of 1978, of which 'the Charter' is a part, grandparents can apply to a magistrates' or county court. It does not give grandparents the automatic right of access, only the right to apply for access, but is a much simpler and less expensive procedure than the previous one.

Grandparents, like other elders, have probably dropped in status during the course of time (page 16). Although they may be equally well, if not more, loved by their grandchildren the term 'grand' does not really reflect their position in the family or in society. The prefix 'grand' is derived from the French adjective *grand* (male) or *grande* (female) which is a translation of the Latin adjective *magnus*. The prefix 'great', as in great-grandfather, is from the same source. The German language also implies venerability; the word for grandfather is *Grossvater* but the term for great-grandfather, *Urgrossvater*, has a different implication from the English, the prefix *ur-* meaning ancient, not great. In French the word is *arrière-grand'mère*, which implies that the relative is one degree of kinship further removed than the *grand-père*. In the Romance tongues of the Mediterranean completely new words are introduced for grandfather and grandmother. In Italian, for example, *madre* means mother but the word for grandmother is *nonna;* similarly, *padre* cannot be detected in the word for grandfather which is *nonno*. The word for great-grandfather is *bisnonno*, and the prefix *bis-* can be loosely translated as 'again', which implies neither venerability as in the English 'grand' nor antiquity as in the German *ur-*. Portuguese and Spanish are akin to Italian. New words are introduced to name one's parents' parents, as in Spanish *avuelo* for grandfather and *avuela* for grandmother, with the prefix *bis-* being used in each language to indicate great-grandparents. There are marked differences in meaning even between closely

related languages. In both Breton and Gaelic, two Celtic languages, the word for the parent of one's parent can be translated as 'old-father' and 'old-mother' in Gaelic, and as 'father-old' and 'mother-old' in Breton. The order of the constituent words differs but the meaning is identical. When the terms used for the preceding generation are translated, however, a marked difference in meaning is obvious. In Gaelic the word great-grandfather can be translated as 'the older-old-father', whereas in Breton it means 'the father who is gentle and easy-going'. Outside Europe very complicated systems of naming grandparents are found depending on whether they are of maternal or paternal lineage and many have implications of venerability.

Is there any significance in these different meanings of the prefixes used to distinguish one's parents from their parents and from their parents' parents? Does it imply that the English had greater respect for their parents' parents' parents than the Germans?

Grandparents have been more important in the past than they are today but it may well be that their star is in the ascendant. As the proportion of marriages in which both husband and wife work increases and as the number of single-parent families increases so will the need for trusted and capable child-minders like the Russian *babushka* who plays an indispensable role in the Russian economy by minding her children's children.

As children

It is frequently forgotten that many elders are cared for by other elders not just as husbands and wives but as sons and daughters. Many people in their eighties and nineties have children in their fifties and sixties and much of the burden of care falls on them, and they themselves are in many cases disabled to some extent. The problems of single daughters, which have been highlighted by the National Council for the Single Woman and her Dependants (see page 42), are particularly severe but there are many married people approaching, or in the early years of, retirement who are also caring for elderly parents, uncles, or aunts.

Life-style and leisure

The generation gap

It is relatively easy to give an account of the social life of elderly people because it is to some extent similar to that of young people with, however, some important differences, which were demonstrated by the findings of the General Household Survey in 1972.

Table 4 Leisure pursuits of elderly people

	Percentage with at least two or three engagements monthly in outdoor activities		
	18–44	*45–59*	*Over 60*
Visiting friends or relatives	80	72	57
Going to a pub or club	70	45	25
Going out for a meal	36	26	20
Driving to the country or seaside	35	35	24
Cinema or theatre	29	9	4
Watching sport	23	19	11
Attending religious services	17	24	24
Bingo	9	16	8

Source. General Household Survey, published in *Profiles of the Elderly*, vol. 1 (Age Concern, 1977).

These appear to indicate that there are significant differences between young and old – a 'generation gap' – but before looking for psychological or practical explanations for the more limited social life of elderly people it should be emphasized that the relatively larger numbers of single women in the older age groups have to be taken into consideration. Women, especially single women, have some limitations imposed on their social life compared with single or married men. Going to a cinema or theatre, going out for a meal or drink, are all much more difficult for single women, especially older single women, although such behaviour is slowly becoming more acceptable. The different proportion of single women in the three groups cannot, however, completely explain the different patterns of social life revealed by the Survey.

At first sight it might appear that these findings demonstrate that elderly people are different from young people. They suggest

the possibility that the older generations lead a much more restricted and narrow social life because they prefer it that way. Evidence, such as the figures given in this table, led certain sociologists to propose that people voluntarily 'disengage' themselves from society as they grow older, but this theory is no longer generally accepted (see page 103) A few people do gradually withdraw from society although they are neither physically nor mentally disabled but most people have sound practical reasons for leading a more limited social life and these reasons largely account for the differences found in the Survey. One very simple reason is that many elderly people have different tastes and enjoy different activities from those who are younger; that is to say, the proportion of elderly people who go out for a meal – 26 per cent compared with 36 per cent of younger people – is smaller not so much because people cut down the frequency with which they eat out, although many do for financial reasons, but because many older people have *never* been in the habit of eating in restaurants. Some old people do take up new hobbies, such as foreign travel, water-skiing, or pony-trekking as they become popular and more easily accessible but most individuals have developed a pattern of leisure activities by a fairly early age, perhaps by the age of 30, and continue with this set of hobbies and interests for the rest of their lives observing new activities and fads with interest, sometimes with disapproval, but electing not to take them up in preference to those which they currently enjoy. Some of the difference between the age groups can therefore be explained by the different biographies of the generations. That is, the difference is not due to the withdrawal of elderly people from society but to the fact that elderly people and younger people can be considered as living in different cultures, each of which has its own life-style and leisure patterns, although both share certain cultural characteristics of the broader society in which they live. This factor does not, however, account for all the differences quoted in the table. Some elderly people cease to follow the same pattern of social activities which they enjoyed when younger for reasons which are not psychological but primarily financial.

The income of elderly people is, on average, lower than the

income of those who are working (see page 76) and this limits many social activities; for example, it is probable that many elders would enjoy eating out more if they could afford the cost of restaurant meals, and the desire and ability of elderly people to venture into new territories if the price barrier is removed, or at least lowered, has been demonstrated by the phenomenal success of SAGA holidays From very small beginnings it has grown quickly to become a multi-million-pound business giving elderly people holidays in places, both familiar and new, at low prices Many elderly people have availed themselves of the opportunities offered by SAGA's skilful management and have travelled to exotic resorts which had previously appeared to be the exclusive province of the young. The SAGA success story is of interest for another reason because it highlights the desire of many older people to mix with those of their own age. Concern has been expressed about activities in which only elderly people participate. Some people, particularly in Britain, have suggested that this is in some unspecified way unhealthy, referring to communities exclusively built for elderly people, such as bungalow cities in America or very large apartment blocks in Europe, as 'ghettos' and making similarly disparaging remarks about old people's clubs or holidays. Those who hold such views maintain that old people should be integrated with the rest of society. This is to a certain extent true. Elderly people should be able to integrate with people of other ages if this is what they wish to do Some do desire this lifestyle, others prefer to be with those of their own generation for part or most of their lives, free from any feeling that they are boring or irritating to younger companions, which is a not uncommon feeling, and secure in the knowledge that the people of the same age with whom they are mixing have had similar experiences and are more likely to share many of their attitudes and values than those who belong to different generations.

The other practical reason why elderly people have a different pattern of leisure activities than those of working age is their immobility which is due partly to the fact that disabling illnesses are more common in later years (see page 147) and partly to the problem previously discussed – poverty. Fewer elderly people have

their own means of transport, or easy access to a motorbike or car, and have to rely on a public transport system which has many inadequacies (see page 105) and is expensive, even with concessionary fare schemes. Not only does this combination of disability and dependence on public transport make a journey to cinema, theatre, or club more difficult, but it makes it more dangerous. Fear of mugging is not uncommon, and is a justified fear in some parts of many cities, and the elderly person who wishes a lively social life has to be prepared to run some risks for the entertainment if it involves walking home or waiting for a bus late at night.

That the more limited social life of old people outside their homes is due less to any internal, psychological reason than to external, social circumstances is also suggested by the findings of the General Household Survey. Those who were interviewed were asked to describe their pattern of activities at home and it emerged that the older people were just as active as those in younger age groups in interests which could be pursued at home.

Table 5 Patterns of leisure activities

	Percentage spending at least one hour daily on indoor activities		
	18–44	*45–59*	*Over 60*
Watching TV	90	93	91
Reading newspapers and magazines	71	82	91
Resting	64	72	80
Reading books	39	38	39
Hobbies, including knitting	32	35	29
Games, cards, puzzles, etc.	16	9	13
Gardening	14	25	34

Source. *Profiles of the Elderly*, vol 1 (Age Concern, 1977).

It could be argued that because elderly people go out less often than younger people they should be relatively much more active at home than younger people than these figures show them to be, but the difference probably would be greater if every old person received all the help for which he or she was eligible. Consider, to give but two examples, how many do not read more because their eyes have not been tested for so long that their spectacles are useless, and how many more would work in the garden if all who suffered from arthritis received specialist investigation and therapy.

There is no evidence that the majority of old people voluntarily withdraw from society; many are forced to withdraw, principally by poverty and disability. There are differences between generations but to dramatize them as a 'generation gap' overstates the case and hides the fact that the life-style of old people differs from that of younger employed people for practical as well as cultural reasons.

Levels of satisfaction

The Survey also asked whether those being interviewed wanted more of each type of leisure activity. Only a minority of elderly people wished to go out more often, and the activity which was desired by the highest proportion was a drive in the country or to the seaside – more than 40 per cent of people over the age of 60 – but most said they were satisfied and the over-all result was that they were more satisfied than those in the younger age groups. The significance of these answers, however, has to be considered in the context of the attitudes of many older people. Members of a generation which has been frequently bitterly disappointed (see page 51) and who are aware that their wishes are unlikely to be met prefer to tell strangers who come to interview them 'I'm all right', than admit to desires which they feel certain will be frustrated (see page 54). The fact that large numbers say they are satisfied should neither be used as an excuse for inaction nor as a reason for complacency. Many elderly people suffer unnecessarily from one or more of the major social problems–poverty, bad housing, cold, and isolation.

7 Poverty

Defining poverty

The word poverty is so commonly used that it may seem unnecessary to define it but it has two meanings which are important to distinguish – absolute poverty and relative poverty – and this distinction is particularly important at a time when there are rapid fluctuations in prices and wages.

Absolute poverty is defined by comparing a household's income with the level of prices of the basic commodities necessary for life – the subsistence level, sometimes called the 'poverty line' or 'bread line'. Those whose incomes are below the minimum level necessary for subsistence are deemed to be in absolute poverty.

The definition of relative poverty is made by comparing a household's income with the average level of incomes in society. Although an individual's income may be sufficient to provide himself and his dependants with the necessities of life he may find his relative poverty extremely upsetting because it symbolizes his low status. J. K. Galbraith, a famous American economist, has described the condition of relative poverty eloquently.

> People are poverty stricken when their income, even if it is adequate for survival, falls markedly below that of the community. Then they cannot have what the larger community regards as the minimum necessary for decency and they cannot wholly escape, therefore, the judgement of the larger community that they are indecent. They are degraded, for in the literal sense they live outside the grades or categories which the community regards as acceptable.

This is an echo of an earlier definition of relative poverty by an even more famous economist, Adam Smith.

> By necessaries I understand, not only the commodities which are indispensably necessary for the support of life, but whatever the custom of

the country renders it indecent for people even of the lowest order to be without.

The first objective of those who introduced pensions was to prevent absolute poverty, to ensure that the old person had enough for the basic necessities of life.

In 1948 it was thought that pensions would have to be increased every five years to keep up with inflation In 1951 it was realized that they should be increased at shorter intervals and they were reviewed every two years until 1971, when it was decided that they should be increased annually. In 1975 it was realized that inflation was so great that a year might be too long a period and the Social Security Act was passed which allowed pensions to be increased more frequently if necessary, but governments have been reluctant to 'index-link' pensions, that is increase them automatically as prices rise, because of the expense involved. Only a small proportion of retired people have index-linked pensions and they are usually those who were formerly in highly paid positions, top civil servants being the group whose index-linked pensions have received most publicity.

The relative poverty of pensioners is only reduced when the pension is increased faster than the rate at which wages are increasing and there has been little change in the relative value of pensions and wages or salary levels. In 1978 the pension was worth twice the amount of money it was worth in 1948 but the increase in relative terms was only from 30 per cent of the average industrial wage to 37 per cent, which was far below the target of 50 per cent set by the Trades Union Congress

In 1974 the Labour government decreed by law that pensions should rise in line with prices or income, whichever was the higher, but in the chillier economic climate of 1979 the Conservative government changed the law. It redrafted the legislation so that pensions need only rise in line with prices although that does not exclude the possibility that they will be increased faster than this if the resources to do so become available.

The prevalence of poverty

The number of elderly people who are in absolute poverty can be estimated from the number who receive a supplementary pension, because only those whose income is below the poverty line are eligible. In 1978 about 1.7 million people received supplementary pensions and the Department of Health and Social Security estimated that about 600,000 more might be eligible if they were to apply. Other measures of poverty are the numbers of pensioners claiming assistance with rent – nearly 800,000 in 1978 – and with rates – 1 8 million in 1978. The level of income at which one is eligible for assistance with rent and rates is higher than the level of eligibility for supplementary pension, albeit not by very much, so that many of those in receipt of rent and rate rebates will be near the poverty line (the numbers quoted for rent and rate rebates underestimate the number in this income group because the proportion of eligible people who actually claim, the 'take-up' of the benefits, is not 100 per cent). In total, therefore, about two million pensioners live below or very near the poverty line. What is hidden by the simple comparison of 'pensioner households' with 'young households', however, is that there is a very wide range of wealth within the group of pensioner households. In general, older people are poorer.

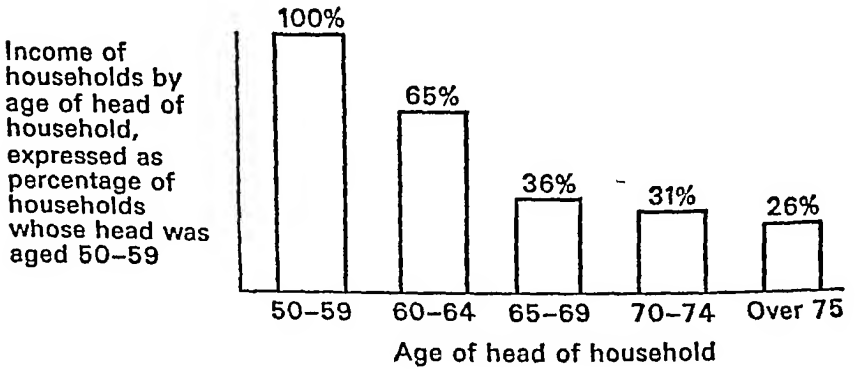

Fig 5 Comparative household income, by age United Kingdom 1975
Source Profiles of the Elderly, vol 1 (Age Concern, 1977).

The main reason why the average income of older elders is less than

that of younger elders is that more of the former depend on supplementary benefits alone as fewer of them have occupational pensions. The higher proportion of women in the oldest age group accentuates this problem and poverty is most common among elderly women, particularly those who have never married.

The impact of poverty

Poverty impinges on the lives of elderly people both in their day-to-day budgeting, most often in relation to the costs of keeping warm (see page 96), and when sudden demands for large sums of money are made of them Owner-occupiers are particularly affected in this respect as the cost of painting, re-roofing, or rewiring a house may exceed their savings and some elders find the cost of the funeral of their spouse a great blow just at a time when they are least resilient. The Death Grant was introduced in 1949 at £20 and was increased to £30 in 1967, at which level it has remained ever since although the cost of funerals has increased dramatically: to be equal in value to the £20 awarded in 1949 the Death Grant should have been £127 in 1979 Furthermore, some old people do not qualify for the £30 grant because they have not paid enough national insurance. In 1979 grants could not be paid for men who died over the age 95 or for women over 90, and the death of men between 85 and 95, or 80 and 90 in the case of women, qualifies for no more than half the grant A number of voluntary organizations set up the Dignity in Death Alliance to fight for higher grants and made an all-party group of MPs take serious notice of this inequity for the first time.

The impact of poverty cannot be assessed solely in relation to specific problems, however, and its influence on all aspects of the elder's life-style has to be taken into account. Financial considerations play an important part in all decisions, not just those which relate to the problems discussed Some older people worry so much about finance that they develop a phobia about debt and refuse to spend what they have on such essentials as fuel and food. To many of us debt is an overdraft and the occasional sticky interview with the bank manager; to them debt may still have strong connotations

of the workhouse and an interview with the relieving officer. The problem has been complicated for some elders by decimalization, and their difficulties are being made worse by metrication. Inflation too can accentuate fears about debt. Most housewives will be familiar with the complaints of husbands, who are less closely in touch with the spiral of price rises, about the amount of money which is spent on housekeeping and so make demands for economy. To the old person who is even more out of touch than such husbands the sudden realization that 'eggs cost twelve shillings a dozen' or 'a pork chop costs nine and six pence' may be so shocking that he may refuse to allow his daughter or home help to purchase such food. Poverty continues to dominate the lives of many old people as it has dominated their lives in the past even though in financial terms they have less need to worry about debt than when bringing up their families in the twenties and thirties.

The prevention of poverty

Some people over retirement age earn enough from employment or from annuities or private occupational pensions to keep themselves out of poverty and are little more dependent on the state then they were while they were working In 1976 24 per cent of the average weekly income of elderly households derived from employment and a further 22 per cent was income from investments, annuities, and private pensions. Many people, however, do not have such sources of income; either because they were compulsorily retired (see page 5) or because they have never been able to invest enough to provide them with their own annuity or pension income. For these people, the majority of retired people, the state prevents poverty by means of the social security system.

Until Henry VIII dissolved the monasteries in the sixteenth century the Church was an important source of succour for people whose families were unable to support them. The state had taken steps to help poor people in the sixteenth century, for example an Act in 1531 distinguished between the sturdy poor people who should be punished and disabled poor people who should be allowed to beg, but it was not until 1601 that the first Poor Law was

passed. The Elizabethan Poor Law remained the basis of statutory social security until the twentieth century but it was increasingly complemented in the nineteenth century by the development of insurance schemes by trade unions and friendly societies, and by the Co-operative Movement. In 1908 old age pensions, payable to those whose income was below a certain level, were introduced by Act of Parliament. This was followed by a law setting up contributory schemes in 1925 and supplementary pensions were subsequently introduced in recognition of the fact that many people would not be able to make sufficient contributions during their working life. During the Second World War a government committee produced a plan for social security in a report named after its chairman, Sir William (later Lord) Beveridge. Published in 1942, its recommendations were implemented, with some modifications, in 1948. It repealed the existing Poor Laws and laid the foundations for a system which has remained largely unaltered until the introduction of the new pension scheme in 1979.

The social security system appears to be a maze, and it is indeed complicated, but its numerous allowances for pensioners fall into two main categories. There are those which are paid to people who have contributed directly to the national wealth, either by paying national insurance contributions or by having given their life or

Social security

Contributory benefits	*Non-contributory benefits*
1. War pensions	1 Supplementary benefits, paid to people whose income is below the poverty line
2. National insurance	2 The old person's pension, paid as a right to people aged over 80
a Retirement pensions	3 Disability benefits
b Widows' pensions	a Attendance allowance
	b Invalid care allowance

Note Rate and rent rebates (page 92) can also be considered as being non-contributory benefits but they are administered by local authorities, not by the Department of Health and Social Security

Fig 6 Social security benefits in the United Kingdom

health in war service; and those which are paid even though the individual has not made such a contribution, provided that they fulfil certain other criteria (The distinction is, of course, artificial for there is no one, no matter how disabled, who does not make a contribution to society.)

Social security is completely different from local authority social services (see page 232) although many people confuse the two, not surprisingly, because both are ultimately controlled by the Department of Health and Social Security, with political responsibility resting with the Secretary of State for Social Services. Social security is paid for by national insurance contributions and taxes, local authority social services by rates and taxes, and more than half the money for local authority services comes from a Rate Support Grant which central government pays from taxes.

National insurance

From the seventeenth century insurance companies grew steadily larger and insured the lives and goods of an increasing proportion of the population However, insurance against sickness and poverty in retirement was too risky for commercial organizations to consider In the nineteenth century non-profit-making organizations, such as friendly societies and trade unions, began to arrange insurance schemes for illness and old age but they could only cover a proportion of the population, and it was realized that the state would have to fund and organize such a scheme to make it both comprehensive and viable. Although there is much of which to be proud in Britain's achievements it was not the first country to start national insurance Otto von Bismarck introduced national insurance in Germany in 1889 as part of his *praktisches Christentum* (practical Christianity) social legislation Insurance against unemployment and illness was instituted in 1912 in Britain and, by another Act of Parliament, old age insurance was introduced in 1926 This was consolidated by the National Insurance Act of 1946 which required both employers and employee to contribute to a National Insurance Fund to provide pensions when the workers retired and to pay pensions to

the widows of contributors. In 1961 the size of the contribution was related to earnings, allowing people to earn an 'earnings-related addition' to their retirement pension, but this scheme was wound up in April 1975 in anticipation of the new scheme to be introduced by the Social Security Pensions Act passed that year.

Retirement pensions are paid to men over the age of 65 and women over the age of 60, provided they have contributed to the National Insurance Fund and have retired from regular work. The pension is reduced if men under the age of 70 and women under the age of 65 are in paid employment because of the earnings rule but after the ages of 70 for men and 65 for women the earnings rule does not apply; the pension is payable whether or not retirement has taken place. By deferring retirement the worker can earn a higher pension. A married woman can qualify for a pension on her husband's contributions, provided she is over 60 when he claims the retirement pension, but many women qualify for a pension in their own right, having paid sufficient contributions while working. In 1976 2.9 million men received national insurance retirement pensions as did 5.4 million women; 2 million of them on the basis of their own contributions, 1 7 million on their husband's contributions, and 1.7 million received widow's pensions.

The government had realized that some elderly people would be unable to make enough contributions to qualify for retirement and widows' pensions, because they would not be able to work for a sufficient length of time between 1948 and the year in which they had to retire, and a non-contributory pension is therefore paid to all people over the age of 80 who have lived in Britain for ten out of the twenty years between their sixtieth and eightieth birthdays.

The national insurance system works relatively smoothly from the pensioner's point of view. The main drawback is that the level at which the retirement and widow's pensions are set is too low; it is actually below, albeit only by a few per cent, the poverty line laid down by the government so that many retired people have to undergo a 'means test', a financial investigation, and claim a supplementary pension to bring their income up to the level necessary for subsistence.

Supplementary pensions are paid to people whose income is

below the poverty line or, in official terms, whose 'resources' are less than their 'requirements'. That is, it is only paid after the person has been subjected to a means test. A person's 'resources' are income from all sources, excluding the first £4, in 1979, of any earned income and the whole amount of certain specified types of income such as George Cross or Victoria Cross annuity or the Attendance Allowance, together with interest from capital over the value of £1,200 (1979 figure), but excluding the value of the claimant's dwelling, furniture, and other possessions. 'Requirements' are calculated principally on the number of people in the claimant's household, although there is a small additional 'requirement' allowance for people who are aged over 80 or blind. In 1978, 1.7 million elderly people received supplementary pensions but only a small proportion depended on it as their sole income and most of the elderly people who were receiving supplementary pensions were also receiving a retirement pension.

Those who are eligible for and receive a supplementary pension automatically qualify for other benefits. Their rent and rates are paid, they qualify for free dental treatment, NHS prescriptions, help with the cost of glasses and with the cost of travelling to and from hospital either as a patient or as a visitor. They also qualify for extra weekly allowances for heating (see page 98) and laundry costs and for extra lump sum payments, called exceptional needs payments, for new bedding, furniture, clothes, or other essential items, but these allowances and lump sums are given at the discretion of the Social Security Officers who assess the application – they are 'discretionary' benefits and are not automatically awarded to supplementary pensioners. These discretionary benefits are the cause of much bitterness, unhappiness, and disquiet.

Those elderly people whose resources are just too great for them to be eligible for a supplementary pension, for example because they qualify for an occupational pension through the payments they made while at work, cannot apply for an extra heating allowance although their house may be just as difficult to heat and their health just as poor as a supplementary pensioner who receives an extra allowance. Many old people are very bitter, feeling that they are being punished for having saved and tried to provide for themselves in old age.

It's not right. You struggle and save all your life then they tell you you can't be helped because you have too much money. If I had spent all my money on drink they would help me. (Mrs S. aged 78)

I now think my mother brought me up wrong. If you lie and do nothing you get help. If you work and tell the truth you get nothing. (Mrs P. aged 74)

Discretionary benefits are also unpopular with many supplementary pensioners. To be awarded such a benefit they must make and argue their case and reveal the extent of their deprivation, for example the poor condition of their bedding, which they may feel humiliating. Furthermore, even if they qualify for an exceptional needs payment they may be excluded from receiving it as a result of having too much money because lump sums are not given to those who have more than £200 capital. This means test within a means test is sometimes a source of anger.

I don't have much but they say they can't help me until I've less than £200. I said to the official I feel like going to blow it and he said he could help me if I did go and spend it. (Mr P. aged 82)

The problems created by discretionary benefits are inherent in the system It is right for there to be discretion in the system and not to have a completely inflexible set of rules but as soon as there is discretion in a system individual judgement is required. This creates strain for the individual who has to make the decision – the job of a Social Security Officer is very demanding – and can create a feeling of resentment and injustice in the person whose case is the subject of the official's decision. It is possible to appeal against discretionary decision but many elderly people either do not apply for discretionary benefits, such as extra heating allowance, or accept the decisions which they feel to be unjust rather than expose themselves to official scrutiny by lodging an appeal.

Disability allowances

During the 1960s increased attention was paid to the problems of disabled people. No single reason can explain this trend. In part it was due to the activities of individual campaigners, MPs such as Alf Morris and Jack Ashley; partly to the pressure generated by pressure groups such as DIG (the Disablement

Income Group); and partly to the publicity given to the effects of the drug thalidomide; but there were many other influences. In response to these pressures the government carried out a survey of the number of disabled people in Britain and then passed the Chronically Sick and Disabled Persons Act in 1970. There was a growing appreciation not only that disabled people were worse off than those who were healthy but that some disabled people received much higher social security benefits than others. For example, those who had been disabled in war or as a result of an industrial injury or disease received higher benefits than other people with a similar degree of disability who had been disabled in some other way, for example as the result of polio in childhood. To redress, or at least reduce, such injustices two allowances for which all disabled elderly people were eligible, irrespective of the cause of their disability or whether they had paid national insurance contributions, were introduced – the Attendance Allowance and the Invalid Care Allowance.

The Attendance Allowance (described in Social Security leaflet NI 205), which was first paid in 1971, is a tax-free weekly allowance payable to disabled people who have needed the attention of another person for at least six months. People are eligible if they need help with tasks such as eating or using the toilet It is also payable to people who require supervision for their own safety. The allowance is paid at two rates: the lower rate – £12 40 a week in 1979 – is paid if a disabled person requires attendance either by day or by night, and the higher rate, which is about 50 per cent higher, is paid if attendance both by day and by night is required. People in hospitals or old people's homes cannot claim the allowance but those who are paying for care in a *private* old people's home or nursing home can apply. An Attendance Allowance is lost after the recipient has been four weeks in a hospital or home but can be received once more on return home if the same conditions are met The payment of Attendance Allowances reflects the much higher frequency of disability in old age than in younger age groups In 1975 nearly half of the allowances paid to men were paid to those over 65 and nearly two-thirds of those paid to women were paid to those over 65 although people over this age constitute only

about one-sixth of the total population. In fact more than one-third of all the allowances paid to women were paid to those over 80 although they form only about 3 per cent of the female population.

Although the Attendance Allowance helped many people one large group of people impoverished by disability were still without any form of social security other than supplementary benefits, namely the relatives who stayed at home to care for disabled people, in particular the single daughters looking after disabled parents who number about 70,000 (see page 68). To help them the Invalid Care Allowance (described in Social Security leaflet NI 212) was introduced in 1976. The allowance is for people of working age who are 'regularly and substantially engaged in caring for a severely disabled person' provided they are neither employed nor a full-time student. 'Regularly and substantially' means 35 hours a week, or more. 'Severely disabled' persons are considered to be those in receipt of an Attendance Allowance, at either the lower or the higher rate, or the Constant Attendance Allowance which can be paid to war pensioners. The Invalid Care Allowance is low, less than the supplementary benefits eligibility level, so anyone who receives it has also to apply for supplementary benefits if she has no other income. However, the Invalid Care Allowance has one great benefit: the recipient is credited with a national insurance contribution each week she receives the Allowance just as though she were at work In 1979 the Allowance was £14 for the carer plus £8.40 for each adult and £7.10 for each child who was also dependent on the carer.

People over retirement age are not eligible for Invalid Care Allowance and a husband over the age of 65 cannot claim for looking after his wife even though he would otherwise be earning. This is the cause of some bitterness but much less than is caused by the government's decision not to award Mobility Allowance to any people over the age of retirement. Introduced in 1976, these allowances, which were worth £12 per week in 1979, are given to people who are unable to walk. Although the government agreed that they were designed principally to help people with education and employment many elderly people felt angry that they were excluded, partly because they saw some younger disabled people

who were neither receiving education nor in employment being awarded this allowance. In 1979 the government stated that it would extend the scheme to older people, but it will take some time before all older people are eligible.

War pensions

Those who died or were disabled in war service are also considered to have made a contribution to the national wealth and pensions are paid to disabled soldiers and their dependents or to their survivors if they die.

Disablement benefit is paid according to the degree of disability resulting from war service. Each military rank has its own scale of payment with a maximum payment for people considered to be 100 per cent disabled with proportionate reductions for lesser degrees of disability. Claimants have the extent of their disability assessed by doctors and expressed as a percentage, rounded off to the nearest 10 per cent; they are then paid that percentage of the maximum permissible for people of their rank. Those who are dissatisfied with their assessment can appeal to a War Pensions Appeal Tribunal. War pensioners are eligible for many other benefits, such as a Comforts Allowance and a Constant Attendance Allowance (which is not the same benefit as Attendance Allowance). An advantage of being a war pensioner is that some other benefits are payable in full in addition to a war pension, for example the Attendance Allowance or retirement pension. Pensions are also paid to widows and other dependants and these benefits are also related to the rank of the deceased person. Officers' widows receive their pension annually, as their husbands did when alive; the widows of 'other ranks' receive a weekly pension. The widows of 'other ranks' receive less than those of officers and within the two groups there are differentials, reflecting the different salaries of the different ranks.

The war pensions service is separate from, but related to, the main social security network, but both are the responsibility of the Department of Health and Social Security. War pension staff concern themselves with all aspects of welfare and receive help from

the Forces Help Society and Lord Roberts Workshops, who use volunteers to link ex-servicemen and their families with funds held by their former regiment or other service unit for financial help and to provide other sources of practical help. At local level representatives of the British Legion and War Pensions Committee visit and support retired ex-servicemen.

Future prospects

Although the national insurance scheme had been modified on several occasions since 1948 none of these modifications had fundamentally altered the principles on which it was based until, in the 1970s, it was decided to develop a pension scheme which would increase the real value of the pension, not only to meet rising expectations but to raise the basic pension level above the poverty line. It was also planned to bring the pensions of women up to the same level as those of men, for women were inequitably treated by the 1948 scheme. Following a long period of discussion the Social Security Pensions Act was placed on the Statute Book in 1975, laying the foundations for a scheme which should operate during the remainder of the century and the first few decades of the next. The main points of the scheme are that it will:

1. Relate pensions to earnings.
2. Allow a worker to calculate his pension on his twenty best earning years.
3. Ensure that pensions will be kept in line with the cost of living.
4. Give women the same right to full equality with men, in that a woman will get the same rate of benefit as a man who has had the same earnings.
5. Enable a widow over the age of 50 to inherit the whole of her husband's pension.
6. Safeguard the pension rights of a woman while she is at home bringing up her family or looking after a sick relative.

This Act, which came into force in April 1978, was drafted to enable the state to act in partnership with the occupational pension schemes run by employers. By 1978 about eleven million workers,

more than half the work-force, were covered by pension schemes organized by their employers and it was hoped that the new scheme would extend the benefits at present enjoyed only by those covered by an employer's scheme to all workers. The new state pension consists of a basic pension, the same amount for everyone who has worked for twenty years, and an additional pension which is related to his previous level of earnings. All employees and employers must contribute to the state's National Insurance Fund for basic pensions but firms which have pension schemes approved by the government's Occupational Pension Board as offering pensions which are at least as good as the state's additional pension can 'contract out', with employees and employers contributing to the firm's own pension scheme.

The political and economic implications of pension policies have become steadily greater not only as a result of the growth of social security, which increased from 5.37 per cent of GNP in 1949 to 8.89 per cent in 1975, but because of the growing power of the pension funds themselves. The surplus in the government's National Insurance Fund was £932 million in 1976–7 but this amount pales into insignificance in comparison with the wealth of the occupational pension funds In some cases the pension fund is run by the employer, for example the Post Office Staff Superannuation Fund had more than 500,000 members and assets worth over £1,200 million in 1978. Other employers use either an insurance company or a merchant bank; for example, Hill Samuel, a leading merchant bank, invested the assets of more than one hundred different pension funds worth a total of £900 million in 1978. Pension funds are investing everywhere Pension funds are buying so much farmland and forcing up the price that it is now proving very difficu't for individuals to buy land. They are still buying property, even though many funds lost money when the property boom collapsed in the 1970s Many now invest in art British Rail Pension Fund spent £11 million of its £478 million on art in 1977, its taste ranging from Picasso's *Blue Boy*, which it lent to the Victoria and Albert Museum, to porcelain, but government securities and shares remain the principle target for pension fund investment managers In 1977 about one-third of all shares and government

stocks were owned by pension funds and the proportion is still increasing rapidly. It may be, however, that the power of the pension funds will diminish as the payment of pensions may, in future, be financed from the wages of younger people who are currently working, a 'pay-as-you-go' scheme, rather than by payments to pensioners from a fund which they themselves built up during their working life, a 'funded scheme'.

Whatever happens one trend seems certain. Pension funds and, to a lesser extent, pensioners will become increasingly important both economically and politically, but poverty will remain a major problem for many years to come, causing distress directly and by its contribution to the other major social problems – housing problems, heating problems, and isolation.

8 Housing problems

The great majority of elderly people – 94 per cent – live in ordinary dwellings, not in institutions. Although it is desirable for old people

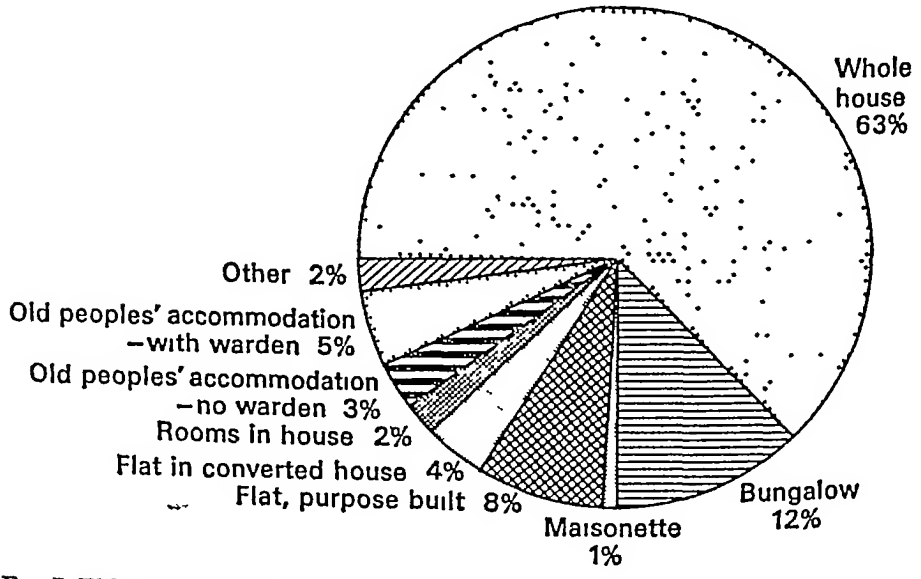

Fig 7 Elderly households · type of accommodation, 1976
Source. *The Elderly at Home* (H M.S O , 1978).

to live in their own homes it must be recognized that this entails many problems, some of which are directly caused by the dwellings in which the elders live. Elderly households are more often without an inside toilet, bathroom, hot water supply, or central heating than younger households In spite of this elderly people had higher levels of satisfaction with their dwellings and the district in which it was situated than younger people in a survey reported by Age Concern in its first volume of *Profiles of the Elderly* (see page 250). It has been suggested that the fact that a higher proportion of old

people owned their dwelling explained this paradox, at least in part, but the differing expectations and attitudes towards their rights of people in different age groups is probably also an important factor (see page 49). The high levels of satisfaction should certainly not weaken our resolve to improve the housing conditions of the elderly people for the poor quality of their housing creates many problems An outside toilet may be acceptable in the summer but the journey to reach it may become dangerous in frosty weather or may become impossible altogether if disability develops; similarly, the district nurse's job is complicated if there is neither hot water nor a bath – she may have to boil buckets of water on the gas cooker before giving a bed bath – and the home help is also handicapped by lack of a proper kitchen and hot water. Poor repair is an important cause of heating problems (see page 100) and bad housing can also give rise to depression and anxiety.

The housing conditions of old people are worse than those of young people for two main reasons One is that there has been a steady improvement in the standard of house design during this century so that newly married people moving into houses built after the Second World War have taken possession of dwellings of a higher standard than those into which today's elderly people moved when they were young married couples forty or more years before. This difference is aggravated because elderly people are, in general, less able to improve and repair their dwellings than young people on account of low income and disability. 'Council', that is local authority, tenants and those housed by housing associations (see page 94) are more fortunate in many ways for repairs and improvements are looked after by their landlords, but only about one-third of old people live in such dwellings. About one-fifth are private tenants, mostly in unfurnished accommodation, and the *Elderly at Home* survey (see page 250) found that those who lived in private rented accommodation had worse housing conditions than owner-occupiers or council tenants – 35 per cent of private tenants had only an outside toilet. (In defence of landlords it should be said that some are themselves elderly and disabled and find the problems of their property, often only one or two dwellings, insoluble because of their own disability and poverty.) Owner-

occupiers also face tremendous difficulties particularly with cost of repairs, rates, and heating

Staying put

To solve this type of problem, thereby allowing the elderly person to continue living in the dwelling and neighbourhood he or she knows, a wide range of services is available.

Table 6 Housing benefits

Problem	*Services*		
	Owner-occupiers	*Private tenants*	*Council tenants*
Poor state of repair Minor, e g broken window	Voluntary Help (page 219)		
Major, e g dangerous wiring	Advice from environmental health officers, with maturity loan from council		Housing Department
Lack of amenities, e g outside toilet or lack of bathroom	Advice from environmental health officer with house renovation grant covering 50 per cent of cost together with a local authority maturity loan, if necessary, for the other 50 per cent		Housing Department
Problems relating to disability, e g steps at front door impossible to negotiate because of arthritis	Advice from domiciliary occupational therapist (page 237) with adaptation if appropriate, e g handrail beside steps or conversion of steps to ramp		
Difficulty with rent or rates	Supplementary benefits (page 79) or local authority rent and rates rebates for those who are not eligible for supplementary benefits		
Legal problems	Citizens' Advice Bureau or Housing Aid Centre		

Impressive though this range of services may be many old people do not benefit from them One reason is that many of the professionals and volunteers who meet elderly people are ignorant of the full range of the benefits available so that some elderly people move from a neighbourhood they love and like because their advisers have been unaware of any solution to their problems other than rehousing A second reason is that some old people hear

of a renovation grant or of the availability of legal advice but are unable to write, phone, or walk to the offices from which they are available and some who could apply prefer not to because they are afraid of getting into debt.

Making a move

For some elders the decision to move to a new dwelling is, however, wise and right Some houses are impossible to improve and adapt, others are situated in unsatisfactory neighbourhoods, for example inner city areas which were satisfactory when the old person first moved in many years before but have subsequently deteriorated. It may be that the main reason for the move is not that the old person wishes to leave the dwelling or neighbourhood but that she wishes to move to live nearer a son or daughter.

A number of different types of new dwellings are available – small houses, bungalows, flats, and the type which has received most publicity, sheltered housing. This is an old concept. Almshouses, the original sheltered housing, have been built for hundreds of years but the almshouse movement is not a thing of the past. It is a thriving and expanding movement today with more than 22,000 properties let in 1977. Most of them have been renovated, but some have been completely rebuilt and retain only their old names The names of the almshouses, which are all listed in the *Year Book* of the National Association of Almshouses, illustrate the different sources of wealth which were used to pay for their construction; for example, Caroline Duchess of Marlborough's Almshouses, the North Eastern Railway Cottage Homes, the Merchant Seamen's Hospital (many are still called hospitals), the Book Trade Benevolent Society's Booksellers' Retreat, the Essex Regiment Memorial Cottage Homes, Bishop Cosin's Almshouses, and the Licensed Victuallers' National Home.

Since the 1960s local authorities and housing associations have built sheltered housing at an increasing rate and about 400,000 old people now live in such accommodation Each group of sheltered flats, usually between twenty and forty in number, has a warden who can be called in emergency as each dwelling has an alarm

linked to the warden's flat. The warden encourages the communal life of the scheme and acts as a good neighbour: she is not employed to nurse or act as a home help, although relatives and other professionals sometimes expect her to do so. In a few instances meals are provided by the warden, in the Abbeyfield homes and the British Red Cross Housing Association, for example, but this is the exception. Sheltered housing is a great benefit to those who are frail and are nervous of living alone but it cannot support a large number of severely disabled people. Each scheme usually has a few disabled tenants but if the warden is called repeatedly by day and night she herself can soon become worn out and unable to cope.

Elderly people who wish to move rarely find it easy to do so except for council tenants who wish to vacate a large house which they now occupy alone because it is to the local authority's advantage to help them move to smaller accommodation. Those who are not council tenants may have to wait years until the local authority offers them a dwelling in the area of their choice and those who wish to move from one local authority to another may find it impossible. Many local authorities give low priority to, or even refuse to consider, the application of old people who wish to move to live near a daughter or son unless the old person formerly lived within their boundaries. Housing associations can overcome this problem because they are funded by central government and are not restricted by such considerations. Anchor, Hanover, and the Royal British Legion, the three largest associations, have schemes in many parts of the country and are not governed by local authority boundaries in the allocation of their dwellings.

Owner-occupiers are often particularly disadvantaged because some councils regard their applications as being of low priority unless there are severe structural problems or unless there are medical indications for rehousing Frequently they receive very few 'points', for most local authority systems of assessing housing need only give points for overcrowding and the lack of basic amenities and they award very few points to someone who is underoccupying a house, even though she is finding it impossible to heat or maintain Equity sharing schemes in which housing associations can use government money to meet part of the cost of

a new dwelling, with the elderly person's contribution from the sale of the dwelling meeting the rest, may alleviate the plight of such owner-occupiers

Owner-occupiers also have advantages, of course. Many people sell on retirement and move to a smaller, more suitable dwelling perhaps near a son or daughter or in a more salubrious area. In a fascinating study called *Retiring to the Seaside* Valerie Karn found that those who migrated to the coast were almost invariably owner-occupiers, many of whom were childless, leaving cities to move to towns they had grown to know and like on vacations, principally because of the more attractive physical environment. The conclusion was that the migration worked out 'remarkably well' for most people although there were problems for over-burdened health and social services.

A large number of problems perplex housing policy-makers. For example, should the emphasis be on rehabilitation of old dwellings or on new building, on bungalows or flats, on sheltered or ordinary housing, on large schemes or small? What is certain is that no single solution can meet the wide range of individual needs What is required is a sufficient range and availability of different types of housing service to allow each elder a much greater degree of personal choice than the majority enjoy today.

9 Cold

In the chapter on hypothermia we emphasize that some old people are at risk of hypothermia because they are less able to feel, or adapt to, a cold environment than young people but that a state of hypothermia usually develops only when they are in a cold environment (page 193). Physical factors predispose to hypothermia; environmental factors precipitate it. The cure of hypothermia requires skilled medical care but its prevention requires social action to decrease the numbers of old people living at risk in cold rooms.

Cold environments are not only important because they put large numbers of elderly people at risk of hypothermia. Many elderly people endure winters of discomfort due to cold and fear of debt even though they are not at risk of hypothermia. A cold environment also increases the difficulties of caring for an old person in his or her own home. Home helps, children, neighbours, and district nurses expend time and energy trying to keep elderly people warm and this physical burden on supporters is accentuated by a psychological burden – anxiety. If an old person is considered to be at risk of hypothermia supporters become anxious and pressure may be exerted, both consciously and unconsciously, on the elderly person to consider moving to an old people's home or a flat with central heating to relieve the supporters' anxiety. Without adequate heating community care in winter is made much more difficult.

Just how many people live in cold rooms was revealed by a survey organized by the National Institute of Medical Research, the Centre for Environmental Studies, and the departments of Geriatric Medicine at University College Hospital and the Royal Free Hospital with financial support from the Nuffield Foundation.

In this study about 1,000 elderly people were visited during the first three months of 1972 and their room and body temperatures measured. The findings were shocking. Ninety-one per cent of the samples had a morning living-room temperature at or below 20°C (68°F) and this at a time when the temperature recommended as being suitable for old people by the Department of Health was 21 1°C (70°F). Fifty-four per cent had a morning living-room temperature below 16°C (60 8°F), the minimum permissible temperature for people at work, as stipulated in the Office, Shops and Railways Premises Act 1963. Their bedrooms were even colder; 33 per cent of the sample had bedroom temperatures which were below 10°C (50°F) and only 1 per cent had a bedroom temperature equal to or greater than the recommended 21.1°C (70°F). More than one-tenth of the old people studied had body temperatures which were lower than 35.5°C (95 9°F) and were regarded as being at risk of developing hypothermia. In his book *Old and Cold – Hypothermia and Social Policy* (see page 250) Malcolm Wicks summarizes the findings of this survey and analyses their implications. These implications are still relevant. The causes of cold dwellings described in this excellent book are many but they fall into three principal categories – the high price of energy, the inefficiency of certain types of heating apparatus, and inadequate insulation.

The high price of energy

To meet the high cost of all fuels retirement, widow's, and supplementary pensions are calculated with respect to the pensioners' price index, the retail price index modified to reflect the different spending patterns of elderly people, particularly their need for greater expenditure on energy. In addition supplementary pensioners can apply for extra help with heating costs if they live in a dwelling which is difficult to keep warm or if they suffer from an illness which immobilizes them or puts them at risk of hypothermia. (The Department of Health and Social Security Leaflet 'Help with Heating Costs' explains these allowances in detail.) In 1977 about one million of the 1.6 million supplementary pensioners

received these weekly heating allowances and all of them received a 25 per cent discount on their electricity bills for the winter quarter amounting to more than £20, and this discount scheme was repeated in 1979 – because electricity continued to be relatively more expensive than other types of fuel. While this system of financial allowances has solved, or at least alleviated, some problems it has created others. As with all benefits which have to be claimed some pensioners who are eligible do not apply for heating allowances (see page 54), other supplementary pensioners apply but are refused, and this makes them bitter, and bitterness is also felt by those whose savings and income, though meagre, are just above the level of eligibility for allowances and discounts.

The provision of money does not necessarily mean that it will be spent. It is not uncommon for professionals and relatives to find that the reason an old person's dwelling is dangerously cold is that she will not switch the heating on even though she can well afford to do so. There are a number of reasons for this. In the first place, most elderly people have been accustomed to pay for a commodity before it is used, which is still the case with coal, but gas and electricity are used before they are paid for. Secondly, 'BTUs' and 'watts' are meaningless terms to many people who therefore cannot estimate the costs they are incurring. Thirdly, many elderly people have always budgeted weekly and find quarterly accounts difficult to manage, and the uncertainty created by these difficulties accentuates the fear of debt, because the term 'debt' still carries implications of eviction and the workhouse to many old people. Much has been done to allay these fears. Pensions have been increased, the fuel industries have made arrangements to preclude the possibility that elderly people will be 'cut off' and have introduced schemes by which an elder can save by buying stamps – but fear of debt remains a common problem which complicates the underlying difficulties caused by the high price of energy for those whose only income is a pension.

Inefficient heating systems

Some elderly people have less money to spend on fuel than others and this obviously causes difficulty, and some have to use the more expensive types of fuel, perhaps because they are rehoused in a new dwelling which is powered completely by electricity. Even if people have the same income and use the same type of fuel, however, some will get much more heat for the money they spend than others depending on the type of heating system which they use. Electricity is the most expensive fuel but the cost of obtaining heat is also influenced by the type of system – radiant bar fires are much more expensive to run than storage heaters set on the correct tariff. Similarly, the amount of warmth generated by a certain sum of money spent on solid fuel will be greater if that fuel is burned in a closed stove than if it is burned on an old-fashioned inefficient grate which loses much of the heat up the chimney.

An old person who is using an expensive type of heating system may be either unwilling or unable to change it to one which is more cost-effective. An open fire is company even though it produces less warmth than if the same amount of money were spent fuelling a gas convector heater and many elders are reluctant to relinquish their fireside hearths. Even if an old person agrees to a change it may be financially impossible to achieve. Supplementary pensioners can claim an exceptional needs payment (see page 98) to pay for the replacement of an expensive heating system with one which is less extravagant; disabled people who are no longer able to cope with open fires may be helped by the Social Services Department; and those who live in neighbourhoods which have been declared smokeless zones qualify for grants but there are many others who cannot afford to change. One other group deserves special mention – those who move into centrally heated dwellings. They have Hobson's choice and, particularly if the central heating is all-electric with no alternative fuel supply, they may find heating expensive but be unable to change to another fuel. It is also essential to remember that the cost of obtaining warmth from electric or any other type of central heating relates not only to the price of the fuel used but to the user's ability to control the heating system correctly

and this is a factor which is especially important in controlling the cost of central heating and obtaining hot water. Many tenants have complained about the cost of central heating when it was an incorrect setting of the thermostat or the time switch which had incurred much of the cost.

Inadequate insulation

No one can afford to waste energy, least of all those who have a low income and an expensive heating system, yet many elderly people lose large amounts of the heat they generate in their dwelling.

Those most at risk of hypothermia are sometimes found inadequately dressed by the nurse, home help, or relative who visits them in the morning. Some do not have sufficient warm clothes and others do not put on those which they have, either because they are too disabled or too forgetful to do so. Old people also lose heat from the rooms in which they live. Commonly the curtains are too thin, allowing heat to escape from windows, and draughts from outside and from the rest of the house also reduce room temperatures and cause discomfort Heat is also lost from unlagged hot-water tanks and through uninsulated walls and lofts, and the cold walls of such dwellings are prone to condensation which increases the inhabitant's misery over her supporters' anxiety. Supplementary pensioners can claim grants for draught-excluding materials; local authorities have insulated many of their properties in schemes linked to the job creation programme to reduce unemployment; and in 1978 parliamentary approval was given for improvement grants (see page 92) to be given to owner-occupiers for loft insulation and the lagging of hot-water tanks Financial help alone is often not sufficient for some old people and voluntary groups, notably Friends of the Earth, have been providing the practical help necessary to carry out the work for those who are too disabled to do so themselves, but inadequate domestic insulation remains a serious problem.

Fire

Heating a dwelling to reduce the risk of hypothermia results in another risk – the risk of fire. Great anxiety about fire is felt by many relatives and neighbours of elderly people and this is to some extent justified because the risk of dying by fire is greater among older age groups.

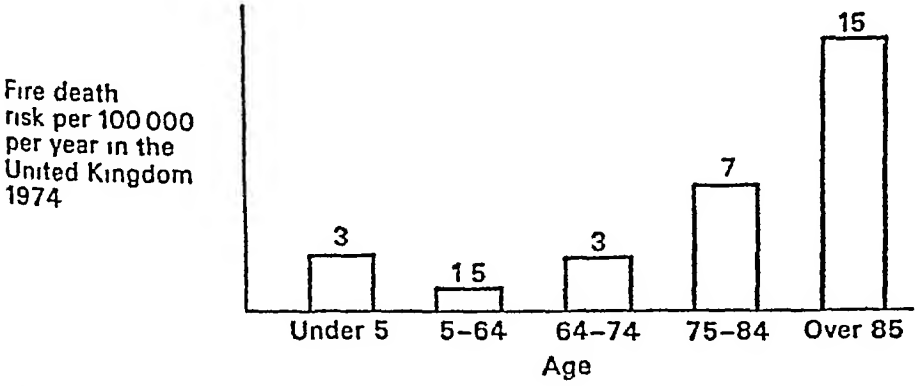

Fig 8 Relative risk of death from fire
Source: Home Office Fire Research Station

Although this anxiety is very common the total number of deaths each year is less than 400 and the commonest causes of fatal fires are cigarettes, pipes, and matches. This does not mean, however, that supporters of elderly people should be complacent about paraffin heaters, faulty wiring, and similar risks, and the Home Office leaflet 'Danger from Fire – How to Protect Your Home', available from Environmental Health Departments, provides clear and helpful advice for old people and their supporters which should be implemented.

10 Isolation

Housing problems can be seen, cold can be felt, and the effects of poverty can be easily imagined but isolation is a more subtle problem which is less easily appreciated and therefore more easily underestimated by young people.

Isolation is not easy to define. One indicator of isolation is the number of other people with whom an individual has social intercourse but this alone is insufficiently sensitive to allow for any accurate measurement.

Not all relationships have the same quality. Although the milkman may be friendly and supportive the relationship established by his wave and smile are not the same as the time spent in conversation with a daughter or an old friend. The former type of relationship may be called a social contact, the latter a social engagement, implying that two personalities engage with each other in a mutually supportive way, discussing feelings, hopes, and other fundamental topics. An elderly person who is happily married may see only two or three people each week in addition to her husband but is definitely not isolated because of the quality of her relationship with her spouse. Both the nature and quality of each relationship have to be taken into consideration.

Even when due allowance has been made for the nature and quality of an individual's meetings with other people the definition of isolation cannot be made on this information alone. There is no standard for isolation comparable to a temperature scale to assess cold. It has to be defined not only with respect to our ideas of what constitutes a normal pattern of social involvement but with respect to the individual's biography and past life-style Some people are naturally more isolated, happy to 'keep myself to myself' or 'enjoy my own company'; others are happier in company. With all these reservations it is difficult to estimate the

prevalence of isolation but some surveys have attempted to do this. The Age Concern Survey *Beyond Three Score and Ten* (see page 64) studied not only the household pattern of elderly people but their isolation. Forty-five per cent of those aged over 75 would have liked to see their offspring more frequently, children being the main source of social contact of those housebound people who have children; 35 per cent of the sample had no living offspring. Using an 'isolation scale' the survey concluded that one-quarter of old people could be considered as being isolated. The Department of Health study of people over 65, *The Elderly at Home* (see page 250), found that 14 per cent of bedfast and housebound neither received visits nor made visits to relatives and friends.

The causes of isolation

Psychological factors are the cause of a person's isolation in some instances Not everyone has the same desire for company, as has already been mentioned, but there are other aspects of an individual's personality which may cause him or her to become isolated Not everyone is equally rewarding; some people are self-centred and uninterested in others to a degree which makes them unrewarding companions. When they are at work or are mobile enough to go out to social functions they are not isolated because they can initiate social encounters although they do not make close friendships easily, but should such a person become housebound he or she is more likely to become isolated than someone who is interested in, and concerned for, other people. The latter type of person is more rewarding to visit and friends, neighbours, relatives, and volunteers will continue to visit because they enjoy doing so whereas they find the unrewarding person depressing and annoying and may stop visiting, which gives the unrewarding person even more cause for complaint, making them even more unrewarding in a vicious cycle. A person who develops dementia may become less rewarding and become isolated; the psychological effects of isolation then aggravate and accentuate the effects of dementia.

It is important to emphasize that old people do not naturally withdraw from society as they grow older. At one time it was

suggested by some sociologists that people voluntarily disengaged themselves from society as they grew older, like snails retracting into their shells, but this theory now has few supporters. In our experience isolation very rarely develops in people as they grow older because of changes in their attitudes towards other people. It is usually the result of physical disease or social forces over which they have no control.

Physical illness is a common cause of isolation. People who are incontinent are often ashamed of their problem and, being uncertain when incontinence may occur, may shun company. Even a single episode of incontinence may lead to isolation because the person fears it might happen when he or she is playing bingo or visiting. If the incontinence is hidden from the old person's helpers, as it sometimes is, the isolation may appear to have no cause.

Instability – falling, and the fear of falling – can isolate because the old person becomes too frightened to walk outside the house. Communication problems – speech difficulties (page 181), blindness (page 177), and deafness (page 180) – obviously isolate a person, as does immobility (page 147). The immobility which results from disease, however, is frequently complicated by the immobility resulting from social factors, principally the relative poverty of older people.

Poverty means that a smaller proportion of old people have telephones although their need is often greater than that of younger people. Social Services Departments can pay for the

Table 7 Number of elderly people with telephones

Age of head of household	*Percentage of households with telephone*
65–74	43
75–84	38
over 85	35

Source: The Elderly at Home (H.M.S.O., 1978).

installation and rental of telephones for disabled people but the amount of money available for their provision is usually very small.

Poverty also increases transport difficulties. In 1977 Alison Norman of the National Corporation for the Care of Old People published an excellent report called *Transport and the Elderly*,

Problems and Possible Action which revealed the multitude of difficulties faced by elderly people. No more than a small proportion of elderly people own or have access to a car, although the proportion varies from one part of the country to another. For example, those who live in the country or who have a higher income are more likely to have access to a car, but in general there are fewer car-drivers in old age.

Table 8 Proportion of elderly people holding full driving licences

Age	*Men* (*percentage*)	*Women* (*percentage*)
50–59	68	19
60–64	60	10
65–69	43	8
over 70	21	2

Source Alison Norman, *Transport and the Elderly, Problems and Possible Action* (National Corporation for the Care of Old People, 1977).

Expense is not the only reason why the percentage of people holding a car licence and having access to a car is lower in older age groups, although it is an important one. The law requires holders

Table 9 Reasons given by elderly people for giving up their use of a car

Reason	*Percentage*
Death of spouse who was the driver	29
Expense	22
Driver disabled or in poor health	12
Driver retired	7
Other reasons	28

Source. *Profiles of the Elderly*, vol 4 (Age Concern, 1979).

of ordinary licences to be medically examined at the age of 70, and every three years thereafter, and some elderly people fail these medical examinations, often because of failing eyesight. Another reason why the percentage of people holding a full licence is lower in older age groups is that a higher proportion have never held a licence Because of their limited opportunities for transport by car, retired people are more reliant on public transport, especially bus services, than those of working age.

The cost of travel by bus is high for those who must make frequent journeys although most local authorities now have some scheme to help elderly people with fares Some give a limited

number of free passes or concessionary tokens, others allow reduced fares on all journeys; some place no restriction on the use of public transport, others restrict its use to 'off-peak' travel, and the different policies of two neighbouring authorities can create jealousy and bitterness because one old person may be very much better off than another who lives near by. It has been estimated that nearly 90 per cent of old people are eligible for a concessionary fare scheme; the total cost of these schemes in England and Wales was £74 million in 1976–7 but cost is not the only obstacle. The network of bus services is shrinking, the one-man bus frightens some elders who miss the conductor's friendly eye which saw them safely seated before the bell was rung, and the height of the bus step makes it impossible for many people to get on or off a bus safely. By careful design of the bodywork and positioning of handrails, British Leyland have produced a bus which is much better for disabled people, claiming that it would be safely accessible to the two and a half million people who cannot easily use conventional buses. Unfortunately, it costs £5,000 more than a conventional bus so it will be a long time before the nation's fleet of buses are suited to the needs of all potential bus travellers. One hope for the future is the development of new types of bus service, for example the postbus, but for such initiative to flourish governments will have to show a much greater commitment to public transport than they have in the past.

Unable to use cars or buses, many elderly people have to rely on special types of transport which also have their difficulties. For example, the ambulance service is not allowed to take people to health centres, although the closure of branch surgeries on the opening of health centres has increased the distances which many patients have to travel to consult a general practitioner. Another problem is that some day centres are unable to help those disabled elders who would benefit most from attending because the local Social Services Departments are unable to provide sufficient transport to bring them to the centre from their homes. Although very many complaints are made about the ambulance and social service transport services it should be remembered that the drivers are a major source of social support for the people they collect. They are employed to convey the patients to and from day centres

and hospitals but they perform a whole range of services in times of need: shopping, firelighting, caring for pets, even dressing the old person if he or she has been unable to do so before the ambulance arrives. It is also important to acknowledge the contribution made by the thousands of ordinary car drivers, many of them retired people, who act as voluntary drivers in essential services such as the hospital car service and meals-on-wheels delivery.

The effects of isolation

As we have emphasized, no two individuals respond identically to the same degree of isolation. Not only does the old person's previous pattern of social involvement influence his response but so does the rate at which disability develops It is usually easier to adapt to a slowly progressive disabling disease than to one which disables quickly, and most difficult to adapt when disability occurs suddenly as the result of a stroke (see page 197). Another important factor is the individual's adaptability, as some people are better able to adapt than others to the challenge of isolation.

From the point of view of the old person loneliness is the most important effect. The true extent of loneliness among isolated people is difficult to estimate because the willingness to admit such a feeling to an interviewer varies widely from one person to another. Some isolated lonely people prefer not to admit loneliness, others realize that it is unlikely that their isolation will ever be relieved and their denial of loneliness to others is part of a defensive technique by which they are able to deny their loneliness to themselves, at least for part of the time. Isolation and loneliness do not invariably occur simultaneously. Some people who are isolated are not lonely, and are happy with their own thoughts and hobbies, and some who are not isolated feel lonely, being unable to make friendships. However, loneliness is a common consequence of isolation and it leads to the dependence of the isolated person on other people.

Dependence occurs in all disabling illnesses but young people usually know that their disability is only temporary. Disabled elderly people, on the other hand, often have to face the fact that

no matter how hard they co-operate with the professionals trying to help them they will never again be fit enough to walk to the shops, pub, and church or to visit their friends. They appreciate, usually unconsciously, that if they become independent, for example able to bathe or cook by themselves, the major consequence will be that they will lose the visits of the district nurse and home help who were sent in as professionals but who have become friends.

When elderly people become isolated by physical disability not only does the number of people they meet decrease but the nature of their social network may change. For example, an elderly person, housebound by disability, may see and relate to not more than ten people weekly of whom half are professionals, such as the home help, the housing assistant, the district nurse, the GP, and the meals-on-wheels visitor. Of course professionals are people and in any professional relationship there is a personal element, which grows stronger the longer the professional continues to visit regularly, but the nature of the professional/client relationship is different from that between friends. Most retired people depend on the state for their income and many rely on state help with their housing costs and it is this reliance, this dependence, which is one of the most distressing aspects of compulsory retirement (see page 9). If, in addition to this basic dependence, the elderly person has to rely on the state for many of her everyday needs and for a considerable part of her social life she becomes isolated as a person, even though she receives many social engagements as a client. The consequence of this may be that the old person does not try to overcome her disability to the extent that she could. She appreciates that if she becomes 'better' from a medical point of view all the services which visit her may be stopped although she is still unable to walk to the church, shop, or pub and she may therefore become worse off from a social point of view. Many old people depend on their disabilities and illness to bring them companions and to maintain their social life.

Mrs S had been in hospital for three months with an ulcer which was very resistant to the nurses' efforts She enjoyed hospital and did not want to return to her home particularly The reason why the ulcer was not healing

was eventually 'diagnosed' – she was observed rubbing the ulcer on the edge of her locker when she thought staff were not looking.

This is a very dramatic and obvious example. Usually the old person is unaware of the motives which reduce her determination to struggle to overcome her disabilities.

Isolation can also contribute to nutritional problems. Serious nutritional deficiencies are rarely due solely to isolation, but the fact that they are isolated does affect the nutritional status of many elderly people. Eating is a social habit and not merely the response to instinctive drives. We usually eat in company and those who live alone not infrequently lose their appetite and the desire to cook or to eat a balanced diet. Meals-on-wheels, which are delivered to about 200,000 people each week, can alleviate this problem although, in some cases, the visit of the volunteer delivering the meal is at least as important as the food in stimulating the housebound person's appetite and preventing nutritional problems. Lunch clubs are therefore even more effective in the prevention of nutritional problems, and the number of meals provided in clubs is now increasing more rapidly than the number supplied at home. Isolation can cause mental disorder. Just as muscles and bones waste away if they are immobilized in plaster and not used, so does the mind waste if a person is isolated. In experimental conditions mental changes can be detected after forty-eight hours in isolation Disorientation in time and space, anxiety, depression, delusions of persecution, and other symptoms occur in many people who are isolated, even young fit people Elderly people may be isolated for more than seventy hours from Friday lunchtime when the home help leaves until Monday morning when the nurse comes, and they are also frequently isolated for shorter periods during the week. The effects of isolation in old age are of course often complicated by the effects of sensory deprivation due to visual impairment or deafness. The effect of isolation lasting over many years cannot be accurately assessed in individual cases but it is almost certainly a significant factor in many cases of mental disorder (see page 118). Isolation is used as a means of brain-washing by 'intelligence' services and this practice is rightly condemned However, many elderly people are brain-washed by isolation without any protest being made.

Prevention and cure

Better education can probably make people more adaptable and better able to cope with isolation if it should occur. Someone who has developed a broad range of interests, some of which can be sustained by reading, writing, and the use of radio and television, will probably be less affected by isolation than someone whose interests have always depended upon being with other people or being physically active. Pre-retirement education is obviously important (see page 11) but education for adaptability has to start at a much earlier age if it is to be effective. Unfortunately, it is not easy to see how we can prevent some people developing unrewarding personalities but many of the physical diseases which cause isolation can be prevented or their effects mitigated by careful assessment and treatment.

If not completely preventable the harmful effects of isolation can often be minimized by early detection and appropriate action. The measures which will be most appropriate depend upon the personality, biography, and social situation of the isolated elder but three types of measures are always important – more visits, more excursions, and more stimulation. More visits to the isolated person by friends, relatives, or volunteers are essential though they may not be easy to organize. What has to be emphasized to visitors is that the more frequently they visit the easier the visit will be and the easier will it be to leave the old person, for those who receive few visits may be reluctant to see their visitors go. More excursions to relatives or friends, to the church or the pub, or to a special day hospital or day centre (see page 229), using voluntary or official transport, not only allow the old person to meet more people but reduce the psychological effects of isolation because the change of environment is stimulating.

An isolated person can also be stimulated in her own home by ensuring that she has and can see a clock which works and a calendar; that she has a radio and television, if she wishes them; and that she receives newspapers, magazines, and books (many libraries find volunteers to deliver and collect large print and ordinary books to housebound people). Finally, the benefits of pets

should not be underestimated. Cats and budgies not only provide company but they have to be cared for, offering the elderly person the opportunity to be useful to other creatures who are dependent on her.

11 Mental changes in later life

Older people are freed from many of the stressful situations which affect younger people. They are liberated from the problems which work creates and from the demands imposed by children, especially adolescent children. They are also freed from the spur of ambition which drives on working people and creates tension, dissatisfaction, and, if the ambition is not achieved, disappointment and depression. Marriages which were unstable have usually dissolved by the time retirement age is reached and those people who remain married have fewer marital troubles than younger married people. Many other factors could be listed which would appear to make old age a time of mental serenity but all the evidence which is available suggests that elderly people suffer mental upset and disorder at least as frequently as younger people do. The reason for this is that the benefits which old people enjoy are outweighed by adverse influences associated with the diseases which occur more commonly in old age and with the social consequences of growing old in our society. The mental disorder created by these adverse influences can be considered under three headings – disorders of mood, disorders of intellect, and disorders of will.

Disorders of mood

Depression

As we have already emphasized, some of the factors which cause young people to become depressed, for example failure at work, do not affect elderly people but many other social pressures bear heavily upon them. Retirement is a depressing blow for many people.

Life on a low income can be depressing and demeaning. Not only does money rather than the individual's choice dominate decision-making but low income is a continual depressing reminder of low status. The need to apply for financial help and undergo a means test is felt by many people to be degrading and depressing (see page 82). The frequency and enjoyment of sexual intercourse may be affected or completely curtailed by physical disability or feelings of guilt. Isolation frequently causes loneliness and depression (see page 107). Deteriorating housing conditions are very disheartening, especially for an owner-occupier who has struggled for decades to buy and look after his home (see page 91). Physical disease and disability may affect even the most resilient and optimistic person. Death of friends causes depression, and the death of a spouse desolation. The effect of a death on an elder is both direct, due to the loss, and indirect, because each death of a contemporary reminds an old person of his own inevitable death (see page 213). Dependence is depressing. It is not just that a dependent person was previously independent, but he had other people – children, spouse, neighbours, and friends – dependent on him so dependence is a double loss. It is a loss of independence and of the dependence *of* others, both now replaced by a dependence *on* others.

As the term implies, depression is an emotional disorder but the depressed person's behaviour may also be affected and most people become less active if they develop depression. Others become preoccupied by inner physical symptoms and may be considered to be 'hypochondriacs' when their real problem is a feeling of depression.

Depression therefore affects different people in different ways and doctors, health visitors, social workers, and others who work with elderly people always have to be alert to the possibility of depression because suicide is common in old age, especially among elderly men.

The suicide rate has decreased since 1961 although the reasons for this trend are not clear. Better treatment of depression, the contribution of the Samaritans, the change from coal gas to the less poisonous North Sea gas, and better medical treatment of people who have taken an overdose of drugs have all been proposed as

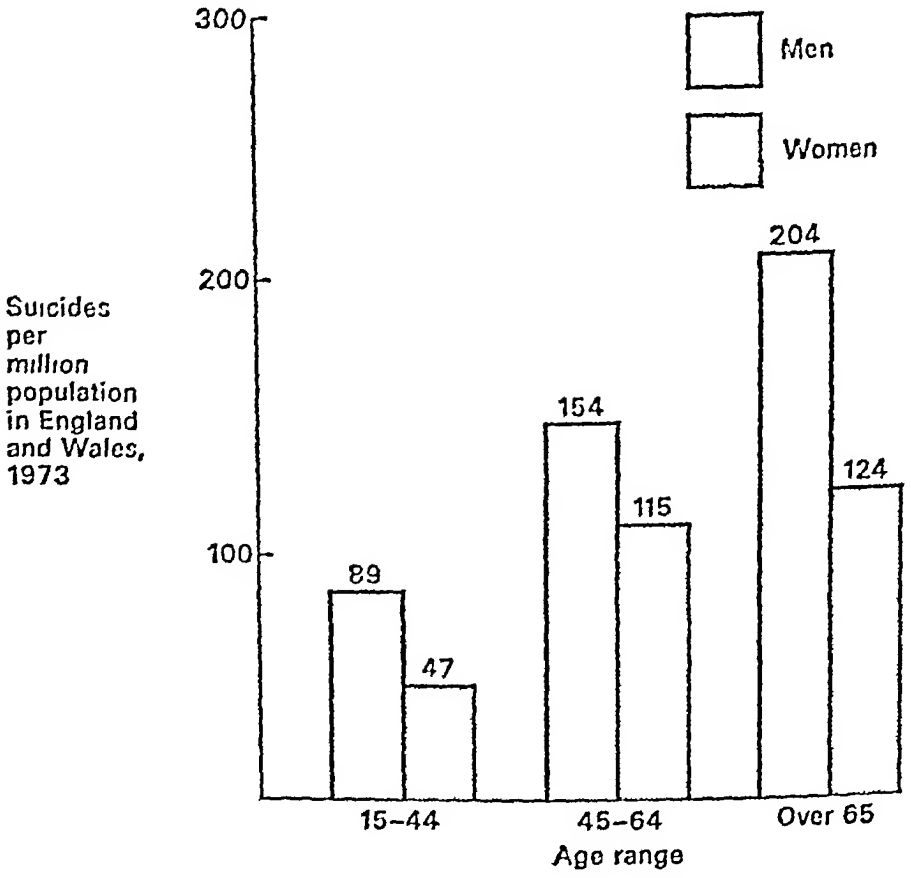

Fig 9 Suicide in England and Wales
Source. *Population Trends*, no. 2 (winter 1975).

possible explanations for the improvement but it could also be argued that elderly people have become less depressed in the last twenty years as pensions and housing conditions have improved and health and social services have expanded. It is probable, however, that no single factor is responsible but a combination of many factors has led to a decrease in the numbers of old people who take their own lives.

Only a small proportion of depressed people are so severely affected that they try to commit suicide and it is usually possible to alleviate the depression before it reaches this stage. The first step when trying to help a depressed old person is identification of the depression. Some people who are so depressed that they become

distracted and unable to concentrate are diagnosed as suffering from dementia (page 136) and a careful assessment is always necessary to distinguish the two, although this is often difficult as both may occur together. The first step in alleviation is not the prescription of anti-depressant drugs but an attempt to solve the underlying problem or problems. For example, a move to a flat in a sheltered housing scheme frequently relieves the depression caused by bad housing and attendance at a day centre or a lunch club run by a voluntary organization can overcome the depressing effects of isolation. If the feeling of depression is not caused by such an easily identifiable problem but seems to come from diffuse and generalized feelings of hopelessness and helplessness it can often be lifted if enough time is taken just to talk with the depressed person. If these approaches fail the next step is for the general practitioner to consider the prescription of anti-depressant drugs which are effective but, like all drugs, do have side-effects so they are not prescribed without due caution. If the doctor thinks that the prescription of anti-depressant drugs for the elderly person to take at home is unlikely to be effective, if, for instance, he considers that there is a serious risk of suicide, he may refer the person to a psychiatric hospital. In hospital the depressed person can be given greater reassurance and the effect of taking anti-depressant drugs correctly can be evaluated, because failure to take the drugs in the manner the doctor intended is a particular problem with these drugs. In hospital the person can also receive ECT (electro-convulsive therapy) – the passage of an electric current through the brain – which can relieve serious states of depression. It is, however, rarely used in older patients because there is some risk attached.

Although general practitioners, psychiatrists, social workers, and psychiatric nurses have to treat the more severely affected people depression is not an illness like diabetes which can only be treated by people who have been highly trained. Their skills are certainly necessary to help some depressed people but depression is largely the result of the way old people are treated by society and the prevention and alleviation of depression must involve every member of society.

Anxiety

Elderly people are free from many of the pressures which provoke anxiety among those of working age. They are free from the demands of work and from the anxieties which result from child-rearing, to give only two examples, but old age brings with it new situations which may generate anxiety because the elder is uncertain what the outcome may be. They may be uncertain whether they will be able to pay all their bills or run up debts. They may be uncertain whether they will be mugged or attacked. Those who have fallen once may have the fear that they will fall again and have to lie helpless and unable to rise. Those who are dependent on others may be uncertain whether they will be able to continue living in their own home or have to go to live in a home or hospital. Those who have been incontinent are often uncertain of their ability to remain continent in company. Those who have been ill may be uncertain whether illness will strike again or not; fear of cancer is a very common cause of anxiety.

It is a tribute to the resilience of the human spirit that old people are not more frequently anxious than they are, when all these uncertainties are considered.

The ability to cope with uncertainty is an individual characteristic. No two people are alike. In general those who were anxious frequently when younger are anxious old people and those who were placid and unflappable when young show the same characteristics in old age, but exceptions are common. Some people who were very anxious during their working life become philosophical in old age, feeling that there are no decisions to be taken in old age which can affect the inevitable changes of ageing, in contrast to their work which could be controlled and demanded daily decisions Others become more anxious as they grow older, perhaps due to attacks of illness or the death of a spouse.

An old person who is anxious may not reveal his anxiety to those who try to help him. He may complain of various physical symptoms to his general practitioner rather than declaring his anxiety; partly because anxiety can cause physical disorders such as headaches; partly because minor physical symptoms are noticed more

by anxious people; and partly because some people are ashamed to admit that they are anxious. Doctors nowadays are not so quick to call a person who brings a number of minor physical complaints to their attention a 'hypochondriac', but try to find out the cause of the underlying anxiety. A person who is anxious may not behave in a manner which is noticeably different from usual but some people who are anxious about a particular type of situation alter their behaviour markedly. If someone has been mugged it is reasonable for him to be too anxious to return to the area in which the crime took place but if he refuses to leave his house, even to go into the garden, then he is said to have developed a phobia. In the same way it is reasonable for an old person to worry about the price of electricity but if he refuses to put on his heating at all, even though he has plenty of money, he can be said to have a phobia of debt.

Anxiety is often relieved without professional assistance. A home help or daughter who reassures an old person daily that she won't have to go into a home may completely relieve her anxiety about this, or the rehousing in a sheltered flat of someone who was very anxious as a result of a break-in and assault (see page 93) may be so effective that the person is able to stop taking tranquillizing drugs. Sometimes, however, the solution of the problem which is apparently causing the anxiety or simple reassurance do not bring relief and the advice of a doctor, priest, health visitor, or social worker is necessary. The initial approach of the trained professional towards a person who is anxious is the same as the approach of a relative or friend. He will try to reassure the person and to find out and solve any problem which he thinks might be the cause of the anxiety. Even if a relative's reassurance has not relieved an old person's anxiety that she will be taken away from her home her general practitioner or social worker may be successful with this approach if their opinion is more highly respected by the elder. Similarly, the old person may reveal a problem to a trusted outsider which she has kept hidden from family and friends so the professional may be able to allay the anxiety. Fear of illness is common in old age and is commonly hidden. An elderly woman may be too embarrassed to say to the son who looks after her that she has been bleeding from the vagina and is anxious that she has cancer. The

benefit of medically examining an old person, therefore, is not only the diagnosis and treatment of physical illness and even if no illness is found the old person may feel much better after a medical check-up because he or she is then confident that no illness is present.

As a last resort tranquillizing drugs, such as valium, can be prescribed for anxious elderly people but, as with depression, anxiety is usually created by a person's social environment and its prevention and management are not just the responsibility of highly trained professionals but of every member of society.

Disorders of the intellect

Disorders of the intellect – failing memory, declining intelligence, and disorientation in time and space – often occur simultaneously in a condition called 'confusion' Such disorders are usually associated with physical disorders of the brain, particularly with dementia (see page 144), but social factors can also cause intellectual disorder. We have already discussed how ageist attitudes can cause problems (page 30) but many other social pressures can cause confusion.

A person who is severely depressed may be unable to think logically or to concentrate enough to remember what she is told and it may appear as though she is suffering from dementia. If depression is not suspected, and not everyone who is depressed tells other people, such symptoms may be dismissed as being due to dementia, which can have very grave consequences if the person has suicidal tendencies. Similarly, someone who is very anxious and agitated may appear to be suffering from confusion due to physical causes. Isolation, as has been mentioned (page 109), can cause disorientation in time and space, hallucinations – hearing or seeing people who are not present – and delusions – beliefs which have no factual basis, such as the belief that one's neighbours are directing radioactive rays through the wall Such thought disorders can be caused by lack of human contact but even those elders who are not isolated may suffer intellectual deterioration due to sensory deprivation – blindness and deafness (page 177). People who are hard of

hearing are specially at risk and may develop delusions that they are being persecuted, a state known as paranoia.

Bereavement combines many of the factors discussed so far, as well as having its own special effect. The loss of someone to whom one has been married for forty or fifty years is not just the death of another person, it is the death of part of oneself – the loss of part of one's own mind. Each person has to try to adjust to this loss just as people have to learn to adjust to the loss of an amputated limb. One type of reaction which distresses relatives and neighbours is the old person continuing to talk to the dead spouse, for instance asking him what type of fire she should install or whether she should move house, but is there much difference between thinking what the husband to whom one had been married for forty years would have said were he still alive and just asking him directly? Most professionals realize how comforting such a relationship can be and do not attempt to interfere with it but neighbours and friends often take a great deal of reassuring.

Moving an elderly person from one environment to another can cause confusion. This effect – called the relocation effect – is familiar to all who work with elderly people. Typically the person moves, or is moved without really appreciating why or where she is going, and the staff in the institution to which she is admitted complain that she is much more disorientated, forgetful, and disabled than they had been told she was. So great may be the difference from what they had been told about her that they may even accuse her relatives or other professionals of lying. This problem is now more generally recognized and appreciated and considerable care is taken before and after a person is admitted to an institution, but unfortunately not in every case Too often a person is moved with insufficient preparation beforehand or support afterwards, either because those who give advice are insufficiently sensitive to the dangers of relocation or because they hold the ageist attitude that all disabled old people are 'dementing' and therefore it is pointless to try to explain things to them or treat them like ordinary human beings.

Mrs T. complained to her GP that her father was becoming very disturbing at home, that he was completely disorientated in time and was turning

night into day. Investigation showed this to be the case. Mrs T.'s father was up frequently at night and slept much of the day. The GP was reluctant to prescribe a hypnotic drug and decided to visit once or twice to build up a better picture of the problem. He visited one day at 3 p.m , Mr S. came downstairs yawning, having had a nap, and said to his daughter 'I'd like some cornflakes for breakfast then some toast', which his daughter willingly provided. After he had left the room the GP asked Mrs T. why she had not corrected him and whether she never tried to impress upon him what the time of day was and what was appropriate behaviour for that hour. Mrs T replied that she never had done so, that her father was over 80 and she had always been resigned to the fact that peculiar behaviour was to be expected 'at that age'.

The origin of Mrs T.'s problem, and its solution, lay in her behaviour towards her father and the attitudes which had influenced it.

Finally, it has to be emphasized that *both* social *and* physical factors have to be borne in mind when trying to assess the origins of a person's confusion because both may be important. People who have dementia, or any other type of brain degeneration, are more likely to become isolated, to be moved from one place to another, and to be underestimated. Conversely, those people who are confused or depressed by social pressures may develop a correctable physical problem of the type which can cause confusion, such as heart failure (page 139) or thyroid disease (page 139), but may not receive the proper medical treatment because they are unable to express themselves clearly. This requires close co-operation between different types of professional – doctors, nurses, psychologists, and social workers – if an accurate and complete analysis of all the factors is to be made.

Disorders of motivation

The response of people to the challenge presented by the limitations which affect people as they age varies widely from one to another. Most adapt to their impairments gracefully, some accept them too easily, and others become very frustrated. A small number, however, appear to lose their enthusiasm for the challenges and opportunities of life to a very marked degree. They

cease to care for themselves or their surroundings and become indifferent to offers of help or encouragement although it appears that neither depression nor confusion can explain their social breakdown.

Miss J. was 82. Since the age of about 60, when her sister had died, she had never gone past the front gate. She lived with her cats in a house which became progressively more dilapidated and dirty. A neighbour bought her food and cashed her pension but Miss J. would not let her buy any new clothes and became more and more dirty and ragged until she was a small, white-faced, bowed figure with knotted hair and tattered clothes. She was always polite and pleasant with visitors and talked happily of her past; she stated that she was satisfied with life and refused all offers of home help, home nursing, medical assessment, and house improvements. For example, she refused to allow her cooker to be converted to North Sea gas although it would have cost her nothing. Her neighbour was worried about the prospect of fire and occasionally bothered by the blocked and smelly drains, but she tolerated Miss J 's demands, although she required regular reassurance from professional workers that she would not be blamed if Miss J. was found dead as she was one winter's morning, apparently having died suddenly.

Old people who become very dirty and refuse help are not uncommon and are a source of great concern to neighbours and professionals who are trying to help them. Section 47 of the 1948 National Assistance Act laid down that people who are 'aged, infirm or physically incapacitated, and, living in insanitary conditions' or who are suffering from grave chronic disease and are 'unable to devote to themselves and not receiving from other persons, proper care and attention' may be removed compulsorily to an old people's home or hospital This power is rarely used, no more than two hundred times per year in England, because the doctors in whom it is vested by the Act – the community physicians – always try to find other ways of coping with the person's problems. Most people who wish to live as recluses are allowed to do so and this is right, provided that this style of life does not suggest that a sudden change in their personality has occurred. For example, if the community physician visits a man living in a dirty house who is obviously neglecting himself he will want to know his biography, what he was like when he was younger. If he has always lived rough and never kept himself and his dwelling clean the community

physician's attitude will be very different than if he were to be told that the man was clean, well dressed, and house-proud until six months previously. In the latter case he would probably suspect that the man had become depressed and had started to drink heavily, a problem often overlooked in older people, or was suffering from some physical illness which was making him confused and unable to manage his affairs.

Why do some old people cease to care for themselves, their appearance, or their home even though they are neither depressed nor confused? No clear answer springs to mind but it could be argued that such an attitude can be explained by the low status of old people (see Chapter 3), public attitudes towards them (Chapter 4), and their own feelings of worthlessness and uselessness (Chapter 5). In some societies prolonged rituals take place after the death of an old person to allow society to adjust to the loss of an important member. In such societies it could be said that a person's social death occurs after his physical death. So unimportant do some old people feel in our society that it could be argued that social death has *preceded* their physical death, that although they are still physically alive their existence seems not to matter to the rest of society and therefore they see no need to observe its standards and conventions. Once more the conclusion is clear; social factors frequently have grave effects on the mind and the spirit of those who survive into old age.

PART II

Growing old: physical changes

12 Physical aspects of ageing

Ageing could be considered an unnatural phenomenon if seen in the context of the animal kingdom as a whole. Natural forces intervene during the life span of individuals of most species and, although they may not necessarily be cut down in their prime, few live long enough to experience the phenomenon which we label normal senescence, and many do not even reach maturity. This is especially true of the smaller species, but is also found in larger animals, for instance in African elephants, where death is often caused by their teeth wearing out before other diseases creep up on them. If one remembers that old age is not an inevitable facet of nature, it is easier to understand its origin in relation to mankind. Here it has probably arisen in part as a result of fewer selection pressures against it since we have learnt to control or avoid those factors which bring about earlier death.

Age changes

Lay people often think of ageing as a combination of changes such as difficulty in hearing, long-sightedness, greying of and loss of hair, and deterioration of memory for recent events together with a collection of diseases which occur more frequently among older people Our elders, however, differ from younger persons in many other ways, and there is a multitude of age changes which do not necessarily constitute disease, and do not necessarily lead to difficulties in living and enjoying life to the full in later years. The first part of this chapter will describe some of these changes, considering different organs in turn

Among the earliest signs of advancing years are those changes in outward appearance that cause concern to the middle-aged, yet delight to the cosmetic manufacturer. The skin becomes less

elastic and unable to smooth out wrinkles, and deposition of pigment leads to the formation of blemishes There are also changes in the small blood-vessels which render them more delicate and increasingly liable to break and cause bruises.

Many of our elders, both men and women, discover that their hair begins to fall out to a greater or lesser extent, leading to complete or partial baldness, especially in men but on occasions in women too Baldness is in large part genetically controlled and little can be done to alter the effects of heredity. It may start unnoticeably as early as puberty, but often it is not until later in life that it becomes very obvious. The familiar greying or whitening of the hair, leading to a distinguished appearance, may to an extent compensate for hair loss and is in the Western world one of the few age changes which are respected or even regarded as a mark of distinction.

Another familiar accompaniment of old age is the need to hold the newspaper and other reading material further away from one's face, and is due to a condition known as presbyopia, or long-sightedness It often begins in the forties and fifties and is caused by changes in the lens within the eyeball, the effects of which can be corrected quite easily with glasses More serious a threat to sight is the development of a cataract, which is also a common phenomenon among older people. Fortunately, many cataracts do not seriously impair sight, and most of those which do can be removed. Degenerative changes may also take place in the retina, which is the light-sensitive layer of the eyeball upon which the lens casts its image, but not many people completely lose their sight. These, in common with other changes in the special senses, are discussed more fully in Chapter 17.

Many of our elders experience some deterioration in their hearing. One of the earliest changes is a loss of the ability to appreciate the higher frequency tones, but despite this, many of the elderly retain excellent hearing for practical purposes, and it is only sophisticated testing that detects this gradual loss, which usually starts in middle age.

The bones become thinner through loss of substance as we grow older, but with a few exceptions there is little change in their shape

and size, although an increase in brittleness leading to a greater tendency to fractures is commonplace. Calcium salts may be deposited in the cartilages and ligaments, making them less elastic than before, and also causing shrinkage. This affects, for example, the cartilage discs between the vertebrae and largely contributes to the loss of height often noticed by people in their seventies and eighties. There is in addition an outgrowth of bone in the areas associated with the ligaments and cartilage. These protuberances are called osteophytes and their presence has in the past led to a diagnosis of arthritis in many people, especially when the bones of the spine have been affected. We now know that in many sites in the body the presence of osteophytes is a part of normal ageing and may be present in older people without any symptoms of any sort. They are therefore often not a cause of worry.

The joints of older people can exhibit changes which are not present at a younger age, but in the majority of cases there is no limitation of movement or resulting disability unless a disease process, that is an arthritis, is genuinely present. Persistent joint discomfort or reduced movement is always due to disease and not old age. That this is obvious can be seen by the frequent occurrence of symptoms of joint disease in one joint, for example a knee, while the other knee is not causing any symptoms at all. Both knees are, however, the same age!

Muscles in many of our elders become wasted and weak. It is not always possible to be certain whether this is an age change in the muscles themselves, or whether it is due to the effects of other diseases Examples of this occur in arthritis and following prolonged bed-rest where disuse of an afflicted joint leads to weakness and wasting of the muscles which usually work the joint. Nevertheless, when one comes to consider movement, it is possible to find changes which probably represent in part the results of the ageing processes in the muscles themselves, for instance an older person's movements are often a little slower and less accurate than when he was younger. There are fewer muscle fibres and more fibrous tissue in the muscles, and this loss of muscle bulk leads to the characteristic thinness of limbs and also hollows in the hands, accentuated by prominent bones.

The changes described in the musculo-skeletal system contribute to the posture adopted by many older people, especially those in their late seventies and eighties: the stooping gait, with bent arms, and the head and neck held a little in front of the body.

The size of the heart remains very much the same throughout life, although its ability to pump blood around the body, and its reserves of power, are reduced in later years. This does not mean that all our elders will suffer from heart failure, since the heart usually retains sufficient efficiency to fulfil normal requirements. Arteries, especially larger ones, become longer and more tortuous as the years pass, and arteriosclerosis commonly causes thickening of the arterial wall. This can be aggravated by certain diseases but is also present in apparently normal people and does not necessarily lead to disease. The structural changes in the arterial wall cause rigidity and contribute to the increase in blood pressure found in many elderly people.

Just as elasticity is lost in other tissues with the onset of later life, so also do the lungs and rib cage become less elastic. This is associated with a reduction in the lung capacity, the amount of air the lungs can hold, and particularly also the amount that can be breathed in and out. The loss of elasticity leads to increased rigidity, and the muscles controlling the rib cage become weaker, causing shortness of breath on exercise even without lung or other disease being present.

The number of microscopic air-sacs, called alveoli, in each lung also decreases and the thickness of their walls increases. Exchange of gases between the air and the blood takes place through the membranes which constitute the walls of alveoli, so the rate at which gases move in and out of the blood must also deteriorate. This is because the thickened wall of fewer alveoli reduces the transfer of gases Under normal circumstances it is not sufficient to cause significant disability, although an older person is often aware that he gets short of breath more easily than he did twenty years earlier.

The membranes of the bowel, and the muscle layer surrounding them, atrophy in later life. The normal onward movement (peristalsis) of the food particles decreases, but not to a sufficient extent

to cause delay in emptying of the stomach. In addition, less gastric juices are secreted in older people. There are also minor changes in many of the other digestive organs, but these are usually insufficient to explain the many digestive problems which appear to be experienced during senescence. However, constipation, probably the commonest, may well be caused partly by the decrease in peristalsis, coupled with the absence of fibre from the diet.

The number of brain cells probably decreases with age. As the most important of these, the neurones, are unable to divide it is impossible to replace them once they are dead. Neurones are therefore as old as the person in whom they are present, in contrast to most other organs where the cells are much younger, having been formed by division from pre-existing cells during that person's life.

The size of the brain may decrease by as much as a quarter, and the ridges on its surface flatten out. Different areas of the brain and spinal cord age at different rates so that, for instance, pain can be appreciated when other sensory stimuli, such as the ability to appreciate temperature or the posture of various parts of the body, are lost. The ability to appreciate a sense of vibration is often the first to go.

Kidney function deterioriates considerably with increasing years so that by the eighth decade the filtering ability of the kidney may be only half that of a 20-year-old. It is specialized parts of the kidney, called glomeruli, that filter the blood in such a way that important constituents do not pass into the tubules which are responsible for forming the urine. This change rarely matters, however, since in the absence of disease there is sufficient reserve to cope with the body's normal requirements.

The reproductive organs atrophy after the menopause in women and later in men Their procreative powers are also lost, although this happens to a lesser extent in men: many septuagenarians have been able to father children. There is also some decline in function of the endocrine glands, the ductless glands which secrete directly into the bloodstream. In particular the pituitary gland and the thyroid gland are known to have a diminishing output of hormones during later years.

The changes described above probably all contribute in part to

the decreased resilience experienced by many people as they grow older. It should also be noted that ageing does not start at a specific stage in life, but that many of the processes involved affect different organs at different stages, and do not happen suddenly. Contrary to popular opinion old age does not, at 65, suddenly arise like a phoenix from the ashes of youth.

Chronological and biological age

It is well known to everyone that certain individuals look their age while others appear younger or older than their years, and even for a doctor it is possible to under- or overestimate a patient's age, on occasions by as much as fifteen or twenty years. When a person's age is measured by counting his birthdays it is known as his chronological age, while the age which would appear to be more in keeping with his abilities and appearance is often known as his biological age. Biological age is difficult to measure, and at the simplest level is based upon a person's appearance, although more sophisticated scales have been developed which assess the number of symptoms and signs of age-related diseases and other phenomena that an individual is experiencing. Chronological age is sometimes used by the medical profession and others as a factor to be taken into account before considering whether an elderly person should undergo certain types of treatment. It has, for example, been common practice to exclude people over the age of 70 from coronary care units. This is an erroneous principle on which to base a decision which may affect whether a patient lives or dies, since it implies that an individual's biological and chronological age are the same, when this is often so manifestly not the case. A man of 71 is usually little different from when he was 69.

Theories of ageing

Of all the possible factors involved in ageing it is likely that genetic and hereditary factors are among the most important. The supreme example of the importance of heredity lies in the field of having children, since if the reader's parents were not able to have them, it is very unlikely that the reader will be able to!!

Most people realize that they inherit genes from their parents and that these help to determine their make-up, for example their height and the colour of their eyes. Genes are in fact complex biological molecules known as de-oxyribose-nucleic acids (or DNAs for short) and are distributed along the chromosomes which are present in the nucleus of each cell. These genes are at the head of complex chains of biochemical and physiological reactions which are responsible for controlling the intra-cellular processes by which we live and which in turn affect how our bodies work. It is reasonable to expect that systems of such complexity would be vulnerable to accumulating errors as the years pass. These errors are especially likely to occur at the time of cell division. Most cells within the body divide in order to repair and regenerate tissues and organs, and the chromosomes are intimately involved in this process An error arising from a mistake at cell division would be passed to future daughter cells, and would consequently be perpetuated so long as the cells are not so badly damaged that they perish. When one considers the enormous number of cells within the body and the number of cell divisions during an individual's life span, it is truly remarkable that serious errors do not accumulate more frequently than they appear to.

Each individual inherits a set of genes from both parents at the moment of conception. This blueprint will to a certain extent mirror that of the parents, and in this way many factors, including possibly the ability to resist making errors of the types mentioned, or to cope with them, may be passed on, determining the rate at which the body 'wears out'.

Over the years many other theories have been proposed in order to explain the biological changes involved in ageing. Many of them have fallen by the wayside as medical knowledge has advanced, and space precludes detailed consideration of all of them. Two of the more recent theories will be described briefly, although they are probably of less relevance than the genetic mechanisms. The scientific study of the ageing process is called gerontology, and much of the interest in gerontology is currently focused on the mechanisms of ageing.

Examination of tissues from a variety of ageing organs reveals in

many the accumulation of fatty pigments in increasing quantities as age progresses. In particular, attention has been focused on the build-up of one of these, a substance called lipofuscin, in the cells of the heart, brain, kidneys, and liver. It has been considered that this build-up may interfere with the normal functions of the cells, perhaps by affecting the complex reactions which take place within the intra-cellular structures. Although this theory is attractive, it does not explain many of the features of ageing, and the pigment is not always present to the same extent in the same organs in different individuals, even though these organs may be functioning at a similar level, that is have aged to the same extent. Despite this, some improvement has been claimed in the ageing brain after treatment with a drug especially developed to stimulate the removal of lipofuscin from within cells. In practical terms, however, most medical authorities have been disappointed with the results of this approach.

There are also those who subscribe to the auto-immune theory of ageing. The body has the ability to produce antibodies, which are proteins in the blood neutralizing or counteracting foreign substances. The body learns by the time of birth which tissues are normal components of itself and is therefore able to recognize foreign or invading material. Under normal circumstances this ability is used to repel infection, and is especially active against bacteria and viruses which are attacked by defence systems of which the antibodies are a part. At times this system works against the well-being of the individual, for instance when a transplanted organ, say a kidney, is recognized as a foreign tissue and rejected, despite careful matching to ensure that it is as similar as possible to the tissue of the person who is receiving it.

On occasions also one of the body's own organs may be attacked by antibodies because the immune system has apparently 'forgotten' that this is a part of itself. It has been thought by some that immunological mechanisms of this sort may also play a part in the ageing process, although this has not been definitely established. It is a possibility, however, that some of the degenerative processes which are associated with ageing could have an immunological background. This attractive hypothesis seems less likely as our

understanding of the ageing phenomenon has advanced, although in this field we are still in our infancy.

Models of ageing

It can be seen from the foregoing account that ageing is a fascinating subject but one that is difficult to investigate, especially within the human being. We already have detailed pathological analyses of human tissues and organs and special knowledge of those changes which occur as the years pass on. However, these shed little light on the basic underlying mechanisms of ageing, and for this reason scientists have turned to other ways of studying the ageing phenomenon Among these have been experiments on laboratory animals, and even the formulation of mathematical models If the former are often criticized as being remote from mankind then the relevance of the latter might be considered even more divorced from reality. Perhaps most hope for a future understanding of the changes in vital aspects of an organism's being will come from study of ageing cells, rather than ageing individuals or animals, since the cell is the fundamental unit of life, and probably the seat of the ageing processes. It is possible to grow a collection of individual cells in special fluids in the laboratory. Under these circumstances they can be carefully observed, and it is often possible to measure changes in their physiology and biochemistry. Cells of connective tissues, which are the supporting materials which hold many organs together, can be grown under these conditions, but only for a limited time. This has been shown to be due to changes within the cells themselves, and not to the deterioration of the medium in which they are growing. As such it could be looked upon as an ageing process within the cells and it is interesting to note that those from older people live and multiply for a shorter time under these artificial conditions than those from younger people Detailed studies of such systems are only just starting, but they are beginning to produce interesting results; for instance, it appears that the effects of certain hormones may prolong the life of cells in culture It is important to sound a note of caution in interpreting the information gained from experiments like these because

they are taking place in isolation from the other processes happening within the body. However, they may have exciting possibilities for the future.

Longevity

Claims are often made for extreme longevity in a particular group of people. On occasions this has been as much as double the normal threescore years and ten that most of us expect, but more commonly figures in the region of 110 to 120 years are quoted. It is a fact, however, that in the Western world in particular more and more people are living into the eighth, ninth, and tenth decades; in 1951 it was estimated that there were about 750 centenarians in Great Britain, but in the 1971 census the figure had risen to 2,430. While some of these are fit, able-bodied members of our elderly society, many more are dependent upon others and may even live in institutional care. This just emphasizes that the quality of life matters as well as its length.

Most of the claims for extreme old age are probably misrepresentations of the truth. Many of the areas where great longevity is reported have no local birth records at all. Where birth certification has been adopted its introduction often postdates the apparent birth date of the supposedly extremely aged person. Parish records have been relied upon in these circumstances, and in some instances have been thought to be faked. Another source of inaccuracy lies in the custom in some communities for children to adopt the family name, so that for instance both the father and the son may be called 'Tom Jones'. Under these circumstances the parent's birth date has been shown in some cases to have been 'adopted' by the child, who is claiming to have lived longer than average. Without adequate birth and death certification such claims are difficult to prove Probably the oldest age which has been confirmed for a British citizen is the 112 years attributed to one Ada Rowe, and also more recently to another lady, Miss Alice Stevenson.

There is no elixir of life or, if you would prefer, of old age. Good health and long life depend upon luck, common sense, and our genes. The latter are inherited from our parents and are not within

our control. Good luck is also beyond our control, leaving only common sense as a factor by which we can influence our destiny. Without good fortune in the other two, however, common sense is not enough by itself to ensure a long life. Happily most old people are content to enjoy their allotted span whatever it may be, and here common sense has a large part to play, especially in terms of preventive medicine, for example in not smoking cigarettes and in eating a sensible diet.

Our life span depends upon the complex interactions of physiological, psychological, and social factors. In one American study the following characteristics were observed in a group of people who had lived longer than their colleagues – high intelligence, financial security, stable marriage, good general health, and a fulfilling role in society. It is comforting to note that at a time when the political freedom which we like to think characterizes our Western civilization is being increasingly eroded, these markers of longer life are as yet pretty well beyond the scope of political manipulation.

It may well be that the present trend towards longer life will continue. However, we are becoming increasingly concerned about the ever-growing numbers of dependent elderly aged 70 or over. It would appear to be sensible first to learn to cope with or avoid the problems which make old age miserable for some and difficult for others, before we look further towards the possibility of prolonging life. Although it is possible that more and more people will continue to grow older, it is unlikely that individuals in our human race will ever be able to live longer than, on average, 110 to 115 years, even taking into account advances in medicine, biology, and society as yet undreamt of.

13 Confusion

As a person gets older he or she is likely to have difficulty in remembering recent events and to become more forgetful. These changes are not inevitable, since many of our elders seem to escape them. When present, they are often accompanied by other manifestations of the ageing process which affect the mind, for instance a more conservative and pessimistic outlook on life, difficulty in concentrating, and a tendency to become less adaptable. It must be emphasized that these changes are normal, but that if exaggerated may herald the onset of dementia, especially if accompanied by disorientation in time or space, for example believing that they are living at a former home with people who are no longer alive. This may progress and be associated with deterioration in personality, impairment of intellect, and worsening of memory.

It has been estimated that between one in twenty and one in ten of all people over 65 suffer with psychiatric disorders, and that one-third of all the elderly in long-term geriatric care have some mental abnormality. The problem is therefore a large one, especially as the number of older people will increase over the next decade or so. Despite this the reader can take heart from the fact that many people have produced great works, or been mentally very active, even in their eighth or ninth decade – G. B. Shaw, P. G. Wodehouse, Somerset Maugham, and Picasso to name but a few. Also, many of those who are confused are only slightly affected and are able to continue to live on their own or with relatives, with only a minimum of support.

The borderline between the mental changes of normal old age and the diagnosis of dementia is blurred. Many older people who superficially seem to have abnormal behaviour are merely exhibiting the eccentricities of their younger days but to an exaggerated

extent. Once a diagnosis of dementia has been made, however, it is of utmost importance to look for an underlying cause, since there is a chance that the condition may be treatable.

Structural changes occur within the brain in apparently normal elderly people in whom there is no evidence during earlier life of any abnormality of function of the nervous system. The surrounding membranes thicken; the brain itself may atrophy, especially towards the front part of the two main hemispheres (the brain is composed of two main parts, one on either side, each called a hemisphere); there is shrinkage of the ridges which make up its surface; and enlargement of the ventricles (hollow spaces within the brain substance). Granules of pigment are deposited within many brain cells, and in some the microscopic structure may change, for instance with the formation of tangles of intra-cellular filaments. Structures known as 'senile plaques' also form, and probably represent local areas of degenerating brain tissue. There was, and to a certain extent still is, controversy as to whether or not the number of brain cells decreases with age.

Some of the changes described above are the only pathological abnormalities to be found in many elderly people suffering with severe confusion or dementia, who are described as having 'senile Alzheimer's disease', or occasionally just 'senile dementia'. This condition is characterized in particular by the presence of many senile plaques, and also tangles of intra-cellular filaments, usually in greater numbers than in normal people. It is difficult to know where to draw the borderline between the numbers of such changes associated with normality as opposed to disease, just as it is difficult to know where to place the borderline between normal mental changes and dementia. Even after a post-mortem examination of the brain the diagnosis may be in doubt.

Of the treatable causes of confusion, one of the more frequent is known as the 'toxic confusional state' and occurs when an illness somewhere else in the body secondarily affects the mind. Many other causes of confusion exist of course, examples being deficiency diseases, infections of the brain, hormonal abnormalities, and other neurological illnesses Some of these are discussed in the following pages, which mainly concentrate on the commoner conditions since they are those most likely to be encountered. It is hoped that

the reader will understand and appreciate the value of early screening of the elderly for treatable disease, especially if the mental changes of normal senescence begin to give way to those indicating early dementia.

Acute confusional states

An acute illness is one with a comparatively rapid onset, for example a matter of hours or less. If it causes confusion this may not occur simultaneously but may take a short while to become apparent. A sudden illness of any type may precipitate confusion in an elderly person, as also can a change in a patient's physical or social state.

The toxic confusional state is one such cause of acute confusion and is most commonly associated with infection, for example pneumonia or a urinary tract infection like cystitis, when toxic products associated with the infection may pass into the blood-stream and eventually reach the brain. In addition, since in the case of pneumonia the inflamed lungs may not function normally, insufficient oxygen enters the blood and not enough carbon dioxide escapes, subjecting the brain to oxygen starvation and the effects of too much carbon dioxide. A urinary tract infection can also result in toxic substances passing into the blood, and waste products may not be satisfactorily excreted if the kidney is also involved, and in turn this too can affect the brain. On the other hand, the source of infection may be hidden, for instance it may reside on the heart valves or within body cavities or joints. Whenever an elderly person suddenly becomes confused it is important to consider whether infection is causing an acute confusional state, especially if his temperature is raised, although the absence of a rise in temperature does not rule out infection, since in our elders this often does not happen when it would in a younger person.

Mrs M.B., a lady of 72, was admitted to hospital because she had suddenly become confused over the previous twenty-four hours. When examined, no obvious cause for this could be found, but she was noticed to have a temperature. A blood sample was sent to the laboratory for examination and found to contain bacteria, indicating the presence of hidden infection,

and she began to improve when this was treated with an appropriate antibiotic. Two days later it became apparent that she had an abscess associated with one of her joints, although earlier there had been no outward sign of this It was successfully treated and two weeks later she returned home, having regained her former self.

Among the other causes of an acute confusional state are conditions in which the ability of the heart to pump blood to the brain is reduced. Heart failure is common in old age, often because of partial obstruction to the heart's blood-vessels, as occurs in hardening of the arteries. Usually the heart failure can be easily and successfully remedied with appropriate medicines.

Heart failure may also be due to a heart attack, in which part of the heart muscle dies because of the complete or almost complete obstruction of one of its arteries, and it may also be caused by an irregularity of the heart rate or rhythm. It is important to realize too that heart failure often arises slowly and insidiously over a period of time and may not affect mental functioning until its later stages. Under these circumstances it is often difficult to diagnose an exact cause.

Total blockage of an artery, as occurs in a cerebro-vascular accident (commonly called a stroke), can prevent any blood reaching a particular part of the brain, resulting in its death – this is known as infarction. If the obstruction forms within the affected artery it is called a thrombosis, while if it travels there through the bloodstream from another source, such as the heart, it is known as an embolus Death of the brain centres controlling movement produces paralysis, as is well known, but permanent confusion may result as well, depending upon which area of the brain is involved. Multiple small areas of infarction can produce dementia too, and haemorrhage into the brain substance also destroys nerve cells, producing a stroke and the possibility of impaired mental functioning. Sometimes the effects of a stroke are short lived with total recovery, and when this happens in less than twenty-four hours it is called a 'transient ischaemic attack'. Strokes are further discussed in Chapter 20.

Mr J.A., aged 83, lived alone and was admitted to hospital because he had suddenly become unable to look after himself When examined, he was

found to be confused and also to have the symptoms and signs of heart failure which had in turn been caused by a coronary thrombosis The heart failure was treated with a diuretic (a drug which causes the kidneys to excrete excess fluid and thereby reduce the load on the heart), and he was given oxygen. His mental function improved as the heart failure responded to treatment, and he was eventually able to return home to look after himself.

Chronic confusional states

The discussion which follows concentrates on some of the commoner conditions which can cause prolonged (that is, chronic) confusion in our elders, and in which medical intervention may be beneficial.

A head injury may cause damage to the brain and subsequent intellectual impairment at any age. The brain is protected by the skull and a blow sufficient to damage brain tissue usually leaves external signs and will be detected in this way, even if the person involved has no recollection of it. There is one condition where this is not always so which particularly occurs in the elderly: this is the subdural haematoma which is caused by the rupture of small veins associated with the membranes surrounding the brain. A large semi-liquid clot, called a haematoma, forms and can occur after a trivial injury which at the time may cause no more than passing annoyance. This may not become apparent until weeks or months later, when it can expand by absorbing fluid and subsequently compressing the brain with an insidious onset of symptoms which often fluctuate in their severity. The patient often complains of a headache and becomes drowsy; sometimes vomiting is a feature, and paralysis can also occur. Since by the time the manifestations are apparent the original injury may have been forgotten, the diagnosis is often unsuspected, and in order to achieve early diagnosis the condition has to be borne constantly in mind, as special investigations are necessary to confirm it.

Brain tumours produce irritation of the surrounding tissues, destroying brain substance and also increasing the pressure inside the skull There are two major sorts of tumour, primary and secondary. The latter arise by spread from another site, for

instance secondary deposits from a breast or lung cancer may grow in the brain, while primary tumours form *in situ*. A brain tumour may present with altered consciousness, epileptic fits, paralysis, and changes in the pulse rate and blood pressure, as well as confusion and specific signs within the eye. The development of the physical signs often occurs over a period of weeks or months, although occasionally haemorrhage into a tumour causes more immediate changes.

In addition to tumours, an intracerebral abscess or haematoma may also cause a similar condition. Under these circumstances the patient's history, and the findings on examination or the use of special tests and investigations, will often reveal to the doctor the nature of the underlying cause. Fortunately both these diseases are relatively uncommon causes of confusion in our elders.

Nutritional deficiencies often exert their effects simultaneously in many different body systems (see Chapter 18) and may lead to or aggravate a dementia. Vitamin B_1 or thiamine deficiency, for instance, can cause relatively rapid delirium associated with changes in the nerves, and a profound and relatively sudden loss of memory is one of the main findings. Another condition which occurs more commonly in the elderly is a deficiency of, or inadequate absorption from the bowel of, vitamin B_{12} or cyanocobalamin. If confusion is caused by vitamin B_{12} deficiency, there will usually also be other signs such as an anaemia (since vitamin B_{12} is necessary for the production of normal red blood cells) and signs of damage to the nerves and spinal cord, often leading to unsteadiness and tingling or numbness in the hands and feet. The neurological changes are due to disturbance in the material (myelin) which acts as a sheath around nerve fibres. The diagnosis is confirmed by measuring the level of vitamin B_{12} in the blood, and treatment, which is necessary throughout life, consists of injections of vitamin B_{12}, at first to replace body stores, and subsequently to keep up with the day-to-day requirements. The mental changes often improve considerably if the condition is diagnosed early enough. Folic acid deficiency is another potential cause of confusion in our elders, and is similarly easily remediable.

Metabolic disorders also commonly cause mental disturbance

and are due to abnormalities of the hormones produced by endocrine (ductless) glands and to malfunction of some internal organs, such as the liver and kidney. Hypothyroidism (commonly called myxoedema) can occur at any age, but is particularly common in the elderly, especially women. It is due to the lack of thyroid hormone as discussed in Chapter 19, and is a diagnosis that is easy to miss, since many of the features are similar to the changes of normal senescence. It has a slow and insidious onset, with symptoms like tiredness, constipation, and intolerance to the cold, as well as confusion. Medical examination will usually reveal further evidence, for instance a slow pulse rate and abnormal reflexes, and people with hypothyroidism are prone to hypothermia too – a condition of low body temperature which may progress to coma and death (see Chapter 19). The diagnosis of myxoedema is confirmed by blood tests which measure the level of the hormone in the blood, and the mental changes may improve when the deficiency is treated with tablets.

Abnormalities of other hormones, for example insulin from the pancreas, and also disturbances of other substances, for example calcium (controlled by the parathyroid gland) and urea (excreted by the kidney), lead to confusion, although they are probably less frequently a cause than is hypothyroidism.

Mrs M.T., a 70-year-old widow, was taken to her family doctor by her son with whose family she lived. He complained that she was becoming more and more forgetful and was often very confused, especially at night. Mrs M.T. complained only of constipation and an increase in weight. The doctor, seeing from her notes that she had previously had part of her thyroid gland removed twenty years earlier because it had then been too active, sent a blood sample to the laboratory. This confirmed that her thyroid gland was not producing enough thyroid hormone, and when this deficiency was remedied she improved significantly over the ensuing weeks.

An anaemia, which is sometimes associated with confusion, is caused by a fall in the amount of haemoglobin in the blood. Haemoglobin carries the oxygen around the body, and is contained in the red blood cells, so it can be seen that an anaemia can be caused by too few red blood cells, or by red blood cells which contain less haemoglobin than usual, but may also be due to a combination of both these factors. In a severe anaemia the amount

of oxygen arriving at the tissues, and in particular the brain, can be less than required to enable the normal physiological processes to carry on and can consequently cause brain disturbance, leading to confusion. The symptoms of anaemia, like so many of the other conditions already mentioned, are often non-specific, such as breathlessness and palpitations, and unless a doctor is alerted by the patient's pallor, and more specifically by paleness of the membranes lining the mouth and the eyelids, the diagnosis may avoid detection. There are many different types of anaemia in the elderly, all of which may be associated with confusion, and in order to improve mental functioning the doctor has to know which sort of anaemia is present, and then also search for the underlying cause. Many anaemias are simple to treat, requiring, for instance, the rectification of nutritional disorders like iron deficiency, or vitamin B_{12} or folate deficiency, as mentioned previously.

Mrs R S., an 89-year-old widow who lived alone, was brought to her doctor's attention because of increasing confusion. She was known to have been muddled in her thinking for many years, but with much support had up until then managed to maintain her independence In searching for the reason for her deteriorating mental state her doctor noted her to be pale, and a blood test confirmed the diagnosis of anaemia It was found to be of the type caused by iron deficiency. Tests in hospital led to the discovery of a large gastric ulcer which had probably been aggravated by some of the medicine she was taking. When these were stopped, the ulcer healed, her blood was restored to normal, and her confusion lessened. Although she was unable to return to live on her own, she was discharged to an old people's home where she lived happily for several years before dying suddenly from a stroke.

There are many other medical conditions associated with confusion in the elderly, and it is unfortunately not possible to describe them all in detail, but three more illnesses are particularly worthy of mention. Occasionally one of the venereal diseases – syphilis – can affect the brain and produce mental disorder many years after the initial infection. If it is not treated early enough the organism responsible (called a spirochaete because of its corkscrew-like shape) travels via the bloodstream to the brain within a year or two of the primary infection, where it destroys cells in the cerebral cortex (the outermost layer of brain cells), producing local tissue

reaction and shrinkage of the brain. The earliest signs may be slight and consists of impaired memory and difficulty in concentrating, but this progresses relentlessly if untreated. The final picture varies in different people, although many patients have one symptom in common – a persistent diffuse headache which is often overlooked since there are so many other causes for headaches In addition to the mental changes there are other signs in the arms and legs, and a person with neuro-syphilis may also suffer with fits The disease is diagnosed by a special blood test, but the result is not always clear cut, and if the test is positive it can be difficult for the doctor to know whether the patient has got active infection or whether the tests indicate earlier treated infection. The treatment is usually a course of special penicillin injections. Fortunately, this condition is becoming rare as a cause of confusion in the elderly.

Hydrocephalus (meaning literally water on the head) sometimes occurs as a congenital abnormality in children when the pressure of the cerebro-spinal fluid surrounding the brain is raised. A similar condition can occur in the elderly, albeit uncommonly, but paradoxically without a significant increase in the pressure of the fluid, and is known as 'normal or low pressure' hydrocephalus, and may be associated with a severe dementia. The other two main features of this cause of confusion are unsteadiness of gait and incontinence of urine It is probably caused by malfunction of the mechanisms which absorb cerebro-spinal fluid, for example by the deposition of fibrous tissue within the drainage system after an attack of meningitis (inflammation of the membranes surrounding the brain), or a haemorrhage into the space normally occupied by the cerebro-spinal fluid, and is diagnosed by a special test using a radioactive substance It can be treated by providing a 'shunt' – an artificial pathway through which the fluid can drain out of the head into a blood-vessel or body cavity. This procedure does not, however, always produce as dramatic an improvement as hoped for, although it may prevent further deterioration or slow it down.

Depression may masquerade as dementia since there is an apparent overlap between the psychological disturbances found in both conditions, such that on occasions an elderly person who is

thought to be demented is found to be depressed. When the depression is treated, normal intellectual functioning can return.

The situation is complex since a patient who realizes he or she is beginning to deteriorate intellectually may also become depressed on this account, and so the two conditions may exist simultaneously. The diagnosis is important because of the excellent response which can result from treatment of the depression.

Drugs

Unwanted effects associated with drugs are discussed in detail in Chapter 21. Medications are an important cause of confusion not only because they are frequently responsible for mental deterioration, but also particularly because this will probably often have been caused by a doctor, however well intentioned. Fortunately, the disturbance of mental functioning is usually reversible when the appropriate drug is withdrawn. Any drug is a potential cause of confusion, which may arise as a known side-effect of the substance or substances making up the drug, or may result as a consequence of misuse by the patient, for example taking too many tablets on one day to compensate for forgetting to take them the previous day. Drugs commonly involved include night sedatives, tranquillizers, digoxin which is used to treat heart failure, those medications used in the treatment of Parkinsonism, and many pain-killers.

Conclusion

Confusion in the elderly, and for that matter in younger people too, can be a very complex medical problem. Although it is often considered by many people to be a normal part of ageing in some of the elderly, this should never be accepted in an individual until an appropriate and careful medical appraisal has been performed.

The doctor has to take a careful history from the patient, or a relative or friend if necessary, perform a complete medical examination, and then decide which investigations, if any, are needed. Often no obvious cause can be found and sometimes,

when an underlying medical condition has been successfully diagnosed, the results of treatment are disappointing, either because the illness is merely one of several contributory factors, or because the damage which has already occurred is irreversible. Under such circumstances one can only hope that perhaps the inexorable progression of mental deterioration has been slowed.

On the other hand, the results can be dramatic, and many people are helped. It is these successes which make it worth while to try and find the cause of confusion in any patient. From a medical point of view the most important problem to resolve is the sudden onset of confusion of short duration. The potential gains from treatment are usually greatest in this sphere, although some of the more chronic confusional states may also respond satisfactorily, for instance myxoedema.

When an old person is subjected to medical scrutiny it is necessary to balance the potential benefit of investigation against the unpleasantness of the tests and the disturbance to their life. It is important to remember, however, that if a cause for the confusion can be found, and successfully treated, the majority of patients and their relatives may have a few more years of happy living restored to them.

Life is often difficult for the relatives of people with senile Alzheimer's disease; in Britain, support and information are available through the Alzheimer's Disease Association, c/o Dept. of Neuropathology, Radcliffe Infirmary, Oxford.

14 'Getting around' – mobility problems

The ability to walk is a fundamental requirement for an independent life. Mobility is often the major bastion of life, allowing our elders to cope with the other diseases which tend to accumulate in some people as they grow older. Immobility means having to come to terms with relying upon others and is often the final straw for relatives or neighbours who are trying to help an old person to live an independent life. Fortunately, the majority of our elders are able to get around sufficiently to maintain their independence.

Many people are partially immobile. They are able, for instance, to walk about on the flat, even though a walking aid or stick is necessary, but may not be able to manage stairs. Despite this, many of them can manage to adapt to living on one floor with the aid of a commode, if the toilet is on a different floor, and if a downstairs room can be converted into a bedroom. An occupational therapist is often able to offer practical advice about the benefit of other aids or alterations, for example ensuring that chairs and the bed are the right height, organizing rails on the wall by the toilet or commode, or as a second bannister up the stairs, if used, and altering the position of the furniture. Special buses are having to be designed to cater for the elderly, since it has been estimated that as many as a million of our elders are unable to mount conventional bus staircases.

There are many conditions which potentially threaten a person's ability to get about Sadly, many of them, although easily remedied, are thought too trivial to need attention until a crisis point is reached. Even more unfortunate is the National Health Service's inability to provide the necessary facilities in many areas to remedy some of the simpler problems even when they are discovered, for example chiropody services.

In the account which follows some of the more important conditions which hamper mobility are discussed. Some of these are fully explored in other chapters, and where this is the case the reader is referred to the appropriate page.

'Minor' disorders of the feet

Although these are minor conditions in the medical sense, they can have just as dramatic an effect on walking as more serious conditions; for example, corns, bunions, ingrowing or overgrown toe-nails, and ulcers and arthritis of the small joints of the foot and toes greatly contribute to mobility disorders. As many as one in six people aged 65 or over may have difficulty in walking because of these conditions, and over all one or more of them may be present in as many as 80 per cent of the elderly. Some of them are self-induced, for example sores caused by badly fitting shoes or inattention to foot care. The importance of paying attention to one's feet cannot be overestimated at any age but particularly so as the years advance. However, many of the elderly have difficulty in bending over to reach their feet, and are unable to use scissors sufficiently well to cut their toe-nails. Ideally most old people should be seen by a chiropodist at least every six weeks or so, especially if they are diabetic or have bad circulation in their legs, since these conditions make the feet particularly liable to problems.

Arthritis

There are many different types of arthritis, but the two that most commonly affect the elderly are osteo-arthritis, now often called osteo-arthrosis, and rheumatoid arthritis.

Osteo-arthrosis occurs most commonly among older people: in one survey over 80 per cent of people late in middle life had X-ray signs of the disease. Since many people do have minimal radiological signs of this nature, but never get any symptoms, it is debatable whether or not all the people really had arthritis, or whether there is overlap between the changes of normal ageing and the

signs of osteo-arthrosis. In the survey only one in five of the people who had X-ray signs actually had symptoms of the condition.

Although osteo-arthrosis is more commonly found in older people, age itself probably does not cause it, although one often wonders whether it is a contributory factor. Previous damage to a joint (as a result of trauma or damage from a different sort of arthritis earlier in life), obesity in the case of some joints, heredity, and a few other rare conditions may all be involved in its contraction.

A joint afflicted with osteo-arthrosis is usually painful or aches and is often very stiff, and it is these discomforts which bring a patient to the doctor. The pain commonly becomes worse when the joint is moved and improves with rest; yet, on the other hand, stiffness may be at its worst after rest, for example first thing in the morning, and improve with movement. The joint may also become very deformed or unstable as a result of the continuation of the disease.

The surface of the bones in a joint is lined with a layer of cartilage which is thought to have many functions, one of the most important being to ensure that there is as little resistance to movement between the articulating (that is, moving) bones as possible. In osteo-arthrosis this cartilage becomes thinned, its surface often irregular, and it fails to perform its normal functions as efficiently as usual.

Among the other changes the most notable are the formation of cysts (spaces filled with a jelly-like tissue) beneath the articulating surfaces, thickening of the ligaments which surround the joint, and also often thickening of the joint capsule (the layer of connective tissue enclosing the joint) These thickened tissues may restrict the normal range of movement of which a joint is capable, which is another feature of arthritis, and in some places, especially at the joint edges, osteo-arthrosis is marked by bony outgrowths called osteophytes. These may, however, also be present without arthritis being involved.

Joints commonly involved in this particular type of arthritis include the hip and the knee, the small joints of the fingers, the vertebrae of the spine, the joint at the base of the big toe, and, less

commonly, the other upper limb joints. The knee is probably the commonest site and causes more symptoms than the others, while the ankle is rarely affected unless it has previously been the site of a fracture.

Treatment can be conveniently divided into two major areas, the first of which is drug therapy. Pain-killing drugs, some of which also help to relieve stiffness, are the keystone of treatment. Initially simple pain-killers can be used, for instance aspirin and paracetamol, but more powerful drugs such as indomethacin and phenylbutazone may be required New drugs are continually being developed and tried in the field of arthritis, and they are a major money-spinner for the pharmaceutical industry. Unfortunately, all drugs have their side-effects, which is also true for anti-arthritic medicines, many of which cause gastric upset and even bleeding into the stomach in some people.

Local measures are the second approach to treatment and can be divided into surgical and non-surgical. Non-surgical approaches include physiotherapy, which is very valuable in many cases, often if only because it gets an old person out of the home on a visit to a sympathetic young lady physiotherapist! Physiotherapy exercises can strengthen weakened muscles and improve the range of motion of a joint Such improvement is often only temporary but nevertheless worth while. There are other local measures employed by physiotherapists, including heat and wax treatments and short-wave diathermy, which are often soothing in their effect, although it is doubtful whether they prove of lasting value.

Surgery is reserved for people with severe disease, since an operation especially in the elderly obviously carries a risk. Surgery to many joints affected by osteo-arthrosis used to employ the techniques of arthrodesis and osteotomy. In the former the two moving parts were fixed together, making the joint stiff and immovable, and this technique is still used in certain situations since it has the benefits of removing the pain caused by the joint's movement and of making the joint stable. Osteotomy, on the other hand, consisted of cutting the bone and realigning it, redistributing the stresses and strains, and is similarly still used in certain instances.

Much of the modern surgical approach is centred upon the

development of the joint arthroplasty, that is inserting an artificial joint, or part of a joint, into the body in place of the diseased tissue. Various types have been designed but the most notable success has been in the hip joint, which can now be replaced with an artificial ball at the top of the femur (thigh bone), and also an artificial socket. Encouraging results are also being obtained in the development of artificial joints for use elsewhere in the body, despite the difficult technical problems posed

Replacing major joints is an expensive procedure but is justified even in the elderly, since if successful it can produce a dramatic improvement in the quality of life, not only for the patient but also in the day-to-day life of the relatives and helpers In younger people, return to gainful employment allows them to reclaim years as a wage-earner rather than existing at the expense of the state, which more than recoups the cost.

One type of osteo-arthrosis deserves special mention since it is common. One often sees people, not always so elderly, wearing a surgical collar because they have osteo-arthrosis in the vertebrae in the neck (although not everybody wearing a collar does so for this reason). As well as suffering neck and shoulder pain, an afflicted person may suffer the effects of arthritis of this site in other parts of the body, for instance in the arms and legs, and, strange though it may seem, neck arthritis can cause walking difficulties.

Fortunately, most of the symptoms experienced by the majority of our elders on account of osteo-arthrosis can be contained, enabling them to make the most of their lives; usually medical measures suffice and surgery can be reserved for the severest cases.

Rheumatoid arthritis is the second commonest type of arthritis and is commoner in women than in men. In the majority of elderly people with rheumatoid arthritis, the disease will have started in younger life and be inactive by the time they have grown older, but it can start again at any age, including during the latter years. In many older people with active rheumatoid arthritis the disease has maintained a chronic intermittent course since earlier years with sudden flare-ups even in their seventies and eighties.

The onset is often heralded by vague joint pains, general malaise, and swelling of several joints, often first involving the

hands and feet and spreading to the larger joints. Affected joints become hot and swollen, painful and stiff, and swellings may appear on the tendons and in the subcutaneous tissues (the tissues just under the skin) around the joint. There is usually deformation of joints and some (notably in the hands) eventually take on a characteristic appearance when the fingers deviate away from the thumb. The main changes initially begin in the synovial tissues (the membranes lining the joint) which become swollen and inflamed, proliferating, invading, and destroying joint cartilage and bones.

Although often thought of as an arthritis, the underlying symptoms stem from a generalized disease process which can affect many other parts of the body as well as joints, such as the eye and the lung, and can even produce an anaemia. Other organs can also be affected, but less commonly when the disease starts in later life.

Many different forms of treatment have been advocated for rheumatoid arthritis but in the elderly, prolonged bed-rest and splintage of joints have to be undertaken with caution. The hazards of the former are described later in this chapter (page 156) but as far as the latter is concerned it is important to note that contractures (fixation of a joint in one position, for instance knees bent at 90°) occur more easily than in younger people.

As in osteo-arthrosis, drug therapy is the mainstay of treatment. The drugs used include those described for the former condition, with the addition of certain other preparations: gold injections; steroid drugs – by both mouth and injection into the joint; and a drug called penicillamine are among those used. Each of these has its own particular indications and complications, and the choice of preparation has to be made carefully.

Surgical treatment of rheumatoid arthritis can take the form of removing the synovial tissue (this is called synovectomy), performing an arthrodesis as described for osteo-arthrosis, and the insertion of artificial joints Among those most commonly replaced are hip, knee, and finger joints As always, an operation has to be considered very carefully, balancing the risks involved with the seriousness of the disease and the discomfort and deterioration in life-style brought about by the arthritis.

Physiotherapy is also important, and the occupational therapist is often able to help the patient relearn basic skills, for instance dressing, even if special aids or trick manoeuvres have to be used.

Rheumatoid arthritis is potentially a more destructive condition than osteo-arthrosis but is luckily much rarer, and considerable relief from its effects can be obtained from modern approaches to treatment.

There are many other types of arthritis which occur commonly in the elderly and which can affect mobility. These range from the well-known phenomenon of gout, to the conditions of pseudogout, ankylosing spondylitis, neuropathic arthritis, and many others (see Bibliography). It is also worth remembering that the Arthritis and Rheumatism Council in Great-Britain plays a major part in disseminating help and advice and also encourages promising lines of research.

There are many other diseases which cause difficulty in walking in our elders. For consideration of some of these the reader is referred to other chapters (strokes, Chapter 20; fractures, Chapter 15; obesity, Chapter 18), but two groups of conditions are described below since they are common and do not fall easily within the scope of different chapters, nor yet warrant a full section of their own in this chapter.

Older people often suffer from swollen ankles and shortness of breath, and this is familiar to most who work with the elderly. When both conditions are present together, heart failure is a common cause, since fluid accumulates in the body, draining by gravity down into the legs to produce swollen ankles, and can also affect the lungs, making the transfer of gases (especially oxygen and carbon dioxide) in and out of the blood difficult, resulting in shortness of breath. In these circumstances, if the doctor is satisfied that heart failure really is the cause, he will probably prescribe tablets, known as diuretics, which act on the kidney to increase the removal of water from the body, and sometimes another tablet such as digoxin may also be required to strengthen the heart. Occasionally the cause of the heart failure can be cured and these tablets may be unnecessary. The 'water tablet', as patients commonly call the diuretic, may result in the loss of too many salts from

the body, especially potassium, and this is why many people also need a potassium supplement, but it is not necessary with all diuretics.

There are of course other causes of both swollen ankles and shortness of breath, but very often swelling of the ankles does not require any treatment at all, or may be due to simple conditions like varicose veins. Occasionally a more serious condition such as a clot in a vein is involved, when it is usually associated with swelling in one leg only. Ankle swelling and its treatment require careful consideration, and if treatment is necessary it is usually simple to improve the symptoms.

Chronic bronchitis, pneumonia, and fibrosis of the lung are other conditions which can cause shortness of breath. Chronic bronchitis is common, and is often self-inflicted by cigarette smoking. Cessation of smoking and seeking assistance before the damage is too great can often produce significant benefit to the sufferer.

The second group of conditions requiring special consideration are due to vascular (blood-vessel) disease, and may lead to difficulty in walking by causing angina pectoris or intermittent claudication. Angina pectoris is chest pain from the heart, commonly caused by insufficient blood getting to the heart muscle through the 'furred-up' blood-vessels, and characteristically comes on after a certain amount of exercise, for instance walking a particular distance, after which the person has to stop while the pain goes away, before proceeding approximately the same distance again until the pain recurs. Many drugs have been prescribed for this, one of the oldest being nitroglycerine tablets placed under the tongue, which can also be used to prevent the pain if taken before exercise. Nitroglycerine can produce side-effects, in particular severe headaches, but other drugs, many longer acting, are also available which suit some elderly people better.

Intermittent claudication is a similar condition affecting the calf muscles in the leg and can be a forerunner of gangrene and the need for amputation. People affected by either of these disorders can often help themselves considerably if they are obese or smoke cigarettes by losing weight and giving up smoking.

Modern advances in surgery and anaesthetics have made it possible for older people to undergo surgery which would not have been contemplated previously. Consequently the number of aged amputees (people who have had an amputation) is rising, such that in 1970 just under three-quarters of a large series of amputees were aged 60 or over. Amputations are most commonly performed on the legs, because the blood supply has become insufficient to support the tissues, leading to the onset of gangrene. The commonest cause for this is arteriosclerosis, which in turn can be aggravated by conditions such as diabetes and smoking.

An amputation is not performed just to remove the gangrene but more importantly to leave a limb which is as useful as possible, and for this reason gangrene of the foot, for instance, may necessitate amputation higher up in the leg, to allow a useful prosthesis (artificial leg or part of leg) to be fitted, rather than a perhaps more cosmetically acceptable but functionally more limited procedure.

An amputation is often psychologically very disturbing, not just to the elderly person but also to his family, and this is often not appreciated by lay people working with the elderly.

Although some elderly amputees finally end up in a wheelchair, there are many more who manage to master the use of an artificial limb, and it is therefore important not to consign them to a wheelchair in the longer term after the operation without an adequate attempt at rehabilitation This may be slow and time consuming but is nevertheless important. Most people, however, will need to use a wheelchair at least initially after their amputation.

As in many other locomotive conditions, rehabilitation does not just mean physiotherapy and occupational therapy in hospital but also assessment and modifications if necessary of the patient's home environment, in order to enable him to live as independently as possible. The outlook is not usually as grim as it at first appears, and many of our elders regain an independent life, free from the pain and discomfort which initially led their doctor to advise amputation.

Consequences of immobility

If an old person has difficulty in getting around, the initial consequences are social rather than medical, resulting in loneliness, inability to get to the shops, causing an inadequate diet, and so on. Many of these problems can be overcome with the help of relatives, friends, neighbours, and voluntary and social services facilities. Once a person becomes bed-bound, however, medical problems often ensue. There are so many consequences of prolonged bed-rest that it is not possible to mention them all but the more serious include pressure sores (places where the skin dies because it has been lain on or subjected to other pressure for too long); pneumonia; thrombosis (clots in the leg veins which can send clots to the lungs); muscle wasting; constipation and incontinence.

It is clear that bed is a bad place to be! This is particularly so when one remembers that most people die there. It is for this reason that we attempt to limit the amount of time our elders have to spend in bed because of illness. An awareness of the potential problems and modern nursing techniques help to minimize the effects of prolonged bed-rest.

Mrs Smith, a 90-year-old widow, lived with her son and daughter-in-law who called in their doctor because she had taken to her bed three weeks previously and they were now having difficulty coping. The doctor discovered that she had heart failure, with swollen ankles and fluid in her lungs, and also arthritis of her knees and painful corns on her right foot. In addition she had developed a pressure sore on her sacrum (the bottom of the spine), and being unable to get to the toilet was frequently incontinent in the bed. He decided she needed admission to hospital, where the heart failure was treated by diuretic drugs, she had chiropody for her feet, and was given pain-killers and physiotherapy for the arthritis. Six weeks later, with the pressure sore healed and her other problems remedied or ameliorated, she was back home living semi-independently as before.

15 Falls

Falls are a major cause of accidents in old age, especially among women. By the age of 70 or so, many older people are already aware of this potential problem and can be seen to take precautions, often subconsciously, during 'high-risk' activities like transferring from a bed to a chair, getting on and off the toilet, and climbing stairs. Although many medical conditions are responsible as the main or a contributory factor, the largest single predisposing cause is the accident hazard. Those that are frequently encountered are inadequately lit and awkward stairs, mats slipping on a polished floor, trailing flexes from electric fires, and falls sustained while negotiating an outside path to the toilet at the bottom of the garden on a cold wintry night. These hazards are all eminently preventable with forethought, either in house planning and design or by a careful assessment of an old person's environment, but so often the necessary adjustment or provision of hand-rails etc. is carried out after attention has been drawn to the problem by a fall. There is an excellent booklet on the subject, called 'Safety in Retirement', available from the Royal Society for Prevention of Accidents, and the local health visitor is also in a position to give advice.

The remainder of this chapter will examine the underlying medical conditions which predispose to falls and consider some of the consequences.

Postural hypotension

A common problem experienced by many of our elders is postural hypotension. The pumping action of the heart maintains a person's blood pressure within certain so-called normal limits, and if these

are exceeded, or the pressure falls below this optimum range, symptoms can develop. When a normal person stands up suddenly the blood pressure may drop, but the heart quickly compensates for the change in posture and returns blood pressure to within the normal range. In older people this mechanism may become impaired, resulting in a persistent fall in blood pressure after getting up out of a chair or out of bed. This state of lowered blood pressure is called postural hypotension, and although a slight drop is present in many people who do not experience any symptoms, larger drops may cause dizziness or faintness and lead to falls, since insufficient blood reaches the brain. The characteristic nature of the fall, that is its relationship to the change in posture, alerts the doctor to this possibility, allowing him to confirm the diagnosis by measuring the blood pressure in the lying, sitting, and standing positions.

Postural hypotension can be caused by conditions which affect the nerves involved in the reflexes controlling the heart; diabetes and, more rarely, syphilis are two such conditions. However, in many old people no definite cause can be found and it may be due to changes affecting what is known as the autonomic nervous system, which is that part of the nervous system controlling our subconscious activities like changes in heart rate, sweating, gastric secretions, and body temperature.

There are also many drugs which can cause or aggravate postural hypotension, including quite common medications like the diuretics mentioned in the preceding chapter, and drugs used in the treatment of Parkinsonism.

The first step in treating postural hypotension is to look for a cause, for example drugs which the patient is already taking, and remedy this. Elastic stockings or a modern tubular bandage called Tubigrip can be used to stop blood pooling in the legs because of gravity, allowing more blood to enter the general circulation, keeping up the blood pressure, and ensuring an adequate blood flow to the brain.

In addition to these measures it is sometimes necessary to resort to other drugs, especially one called fludrocortisone which increases the blood volume by increasing the amount of salt and water in the

circulation and also constricts some of the blood-vessels, making the capacity of the circulation a little smaller. These measures usually suffice to restore the blood pressure to an acceptable level so that the symptoms disappear. There are of course people for whom this treatment is insufficient, and in their cases more complicated remedies may be necessary.

Parkinsonism

Parkinsonism is a condition characterized by a rigidity and tremor of the limbs and difficulty in starting to move. The typical Parkinsonian patient first has a trembling of the fingers while sitting or lying still, often likened to 'pill-rolling' because it seems as if they have a pill which they keep rolling between the thumb and index finger. This spreads to involve more of the limbs and is eventually accompanied by rigidity, that is difficulty in moving them.

People afflicted with Parkinsonism find it difficult to start to do things, and getting up and out of a chair can become a major exercise because they cannot get their limbs to start making the appropriate movements. Once up, however, they develop a rapid shuffling gait and often find it difficult to stop. Unfortunately, the disabilities do not stop there, and other features of this condition include depression, the production of excessive amounts of saliva, a greasy skin, and an emotionless facial mask with a monotonous voice. Falls occur commonly in Parkinsonian patients, partly because they are prone to develop postural hypotension which can be aggravated by the drugs prescribed for their condition, and also because the difficulty in getting out of a chair and in moving predisposes them to falling.

There are many causes of Parkinsonism. Originally it was described as a single disease called Parkinson's disease, but we now know that in some people there are other reasons, and certain drugs, for instance, can produce many of the features, as can some poisons.

Parkinsonism can often be treated extremely successfully with a variety of drugs. One that is commonly gaining popularity is a mixture of two compounds, the most important of which is known

as L-dopa. The other component of the tablet is a substance which allows the L-dopa to concentrate in the brain without causing side-effects elsewhere in the body, but despite this L-dopa preparations, as well as others, can have considerable side-effects, which include postural hypotension and confusion. Management of Parkinsonism includes other measures such as physiotherapy and occupational therapy, and the doctor has to decide which of the many treatment regimes is most appropriate to each particular patient. This difficult task is often made more difficult because it is not always possible to cure every manifestation of the disease, but in general most patients are considerably helped and research into improved methods of treatment continues. In addition, the Parkinson's Disease Society produces excellent leaflets for sufferers and their relatives.

Mr Black, an ex-postman aged 73, was referred to a hospital clinic because of repeated falls. He was already known to have Parkinsonism which was being treated with an L-dopa preparation Examination showed that he had Parkinsonism that was not fully treated, especially the rigidity, and also postural hypotension The treatment for his Parkinsonism was changed to another drug and he was seen three weeks later At this time the postural hypotension was much improved and he was coping with what little dizziness remained by getting up slowly from his bed and chair. The dose of the drug was adjusted carefully during the next six weeks and although some of the tremor remained, the rigidity improved further. Despite being shaky at times he had no further falls and managed to get around safely with a walking aid supplied by the physiotherapist.

Cardio-vascular or circulatory causes

There are two major causes of falls in this area, one the result of abnormalities in the heart's rate or rhythm, and the other of disease of some of the arteries to the brain.

Disturbance of heart rhythm can take the form of cessation or slowness of the heartbeat for a short interval, irregularity of the rhythm, or a rate that is too fast It is easy to understand that absence of the heartbeats for even a short while will prevent blood reaching the brain and result in faintness or a fall, but a very slow heartbeat will also do this, as happens in younger people when they

faint. Falling to the ground often remedies the situation since the slowly beating heart does not need to generate sufficient pressure to push blood uphill against gravity to the brain, since this is now lying at the same level as the heart. Clearly, if the heart has momentarily stopped, this change in posture will not help until it starts up again. A very irregular or very fast heart rate can also have the same effect because the heart's efficiency is impaired, leading to a fall in blood pressure.

Different abnormalities of the heart rhythm need different management, and it is beyond the scope of this book to go into details, but it is appropriate to mention pace-makers. They are becoming an increasingly common phenomenon in the elderly and are often surrounded by a dangerous and erroneous misconception. Many people distrust what is called 'high-technology medicine', and others, including some doctors, believe it should not be applied to the elderly, but both these attitudes are a lot of nonsense unless carefully applied to individual patients. Pace-makers do not just prolong life but restore a quality of life to many people which most of us, even other elderly people, take for granted. These little machines are inserted, under a general or local anaesthetic, beneath the skin, usually on the chest; wires pass to the heart so that when the heart rate falters the pace-maker gives it an artificial stimulus to make it beat with a reasonable rate and rhythm, thereby maintaining the circulation of the blood. Many an older person's life has been dramatically improved by a pace-maker, and our elders should not automatically be debarred from this facility on the grounds of age alone. This does not of course mean that every elderly person with a heart condition should have a pace-maker but rather that each person should be carefully considered on his or her merits irrespective of age One also has to bear in mind that the batteries need changing periodically and this usually means a minor operation from time to time, sometimes as frequently as every two to three years.

Miss Smith, an 83-year-old spinster, was referred to hospital because of very frequent falls Questioning failed to reveal any obvious clues to their cause, but it was apparent that she was living a miserable existence because of them. An electrocardiograph showed that her heart stopped beating

normally from time to time, allowing abnormal heart rhythms to arise, which caused her to lose consciousness and fall. Drugs had only a minimal beneficial effect, so a temporary pace-maker was tried. This was so successful that a permanent one was inserted under the skin on her chest. Six months later she had not had any more falls and was living independently at home, helping her elderly neighbours, some of whom were considerably younger than she.

In the presence of generalized arteriosclerosis most of the arteries to the brain can potentially become partially or completely blocked, although as a cause of falls the arteries to the back of the brain are probably the most commonly involved Starved of blood, even momentarily, the parts of the brain supplied by these vessels are affected, resulting in vertigo and unsteadiness, but if severely affected other signs may become apparent, and occasionally even a stroke can ensue.

There is one particular type of fall, commoner in women, when the knees momentarily give way and the person falls to the ground but rarely loses consciousness, if at all, and then only for a second or so, and is usually able to get up immediately. Such episodes are called 'drop attacks' and apart from the danger of injury they do not usually lead to anything more serious. These are also probably the result of an impaired blood supply to a particular part of the brain and spinal cord, although there is no sensation of vertigo, as mentioned above.

Arthritis of the neck bones also produces interruption of the blood supply because projecting spurs of bone can press on the blood-vessels which lie in close relation to the vertebrae. In these circumstances turning the head or looking upwards can lead to occlusion of the blood-vessel with a momentary black-out and fall.

Unfortunately, these conditions are often difficult to treat, and attention has to be directed to minimizing their impact on the daily life of the afflicted person. Blood-thinning drugs such as warfarin have been tried in some of these syndromes with varying success, but present interest centres on drugs such as aspirin, which in addition to being pain-killers decrease the stickiness of the blood platelets (small particles present in the blood and involved in clotting). There is evidence that little clumps of blood platelets

may block small blood-vessels, and if they can be made less sticky and therefore less liable to clump, blockage of the small arteries involved can be prevented. On rare occasions surgery is needed to unblock a blood-vessel but this is technically a difficult procedure and the long-term results can be disappointing unless the candidates for operation are chosen with extreme care. Most of our elders with these conditions can be helped to a greater or lesser extent.

Epilepsy

Epilepsy is usually thought of as a condition of young people but it is not uncommon in the elderly, many of whom have had it since childhood, albeit with less severity and frequency as the years pass. There are different types of epilepsy but common to most is the uncontrolled rhythmic movement of various parts of the body, usually followed by a period of stupor. In certain types the patient loses control of his bladder and may also injure himself, for instance by biting his tongue, and unless in a bed or a chair the victim of an epileptic attack will of course also fall. If found on the floor after an attack there may not be anything to indicate that he has had a fit, and consequently recurrent falls are occasionally discovered to be due to this condition, which was not orginally suspected.

Epilepsy that starts initially in late life must be investigated by the doctor in order to exclude a serious underlying cause, such as a brain tumour or abscess, but these occur only rarely. There are many more benign causes of epilepsy in the elderly, one example being a scar that forms in the brain after a stroke, which can cause abnormal 'electrical discharges' in the brain, leading to convulsions. Epilepsy can also be caused by problems outside the brain, for instance lack of oxygen or too low a level of blood sugar.

If a person with epilepsy is discovered during an attack it is best not to try and restrain him however violent the involuntary movements appear, but rather to move articles of furniture, etc. out of the way of his thrashing movements. After the attack he should be placed on his side in the semi-prone position, head lying on one arm and mouth and nose unobstructed in case he is sick and drowns in his own vomit. Eventually he will recover consciousness but will

have little or no memory of the episode. A prolonged series of fits should be reported urgently to a doctor since even a mild seizure is a particular hazard to an old person and can on occasion result in broken bones, head injuries, and other catastrophies.

The two drugs most commonly used to treat epilepsy in the older patient are phenytoin and phenobarbitone, and although both of these can have side-effects they are less serious than the epilepsy which they will usually prevent. If certain stimuli are known to precipitate epilepsy in a particular person, avoidance of these whenever possible will reduce the number of attacks.

Other conditions

Among the other conditions which can cause falls are disturbance of those parts of the brain concerned with balance, and in particular abnormalities of the cerebellum and inner ear mechanisms. The former is a small structure at the back of the brain which co-ordinates balance; the latter consists of three structures known as 'semicircular canals' because of their shape, which are embedded in the skull on each side and allow one to appreciate the position of one's body in space Both these mechanisms are essential for normal balance and disorders affecting them lead to unsteadiness and falls. Similarly, anything which interferes with the mechanisms which tell us whereabouts our legs and arms are and allow us, for example, to walk steadily if blindfolded or in the dark, will lead to a tendency to fall. This information is conveyed to the brain by special bundles of nerve fibres running in the spinal cord; it arises from receptors in and around the joints and passes to the spinal cord along the nerves. Deficiency of vitamin B_{12} can affect this mechanism, leading to incoordination of movement and hence falls. Special blood tests are needed to diagnose this condition if an abnormality in this part of the nervous system has been discovered.

Multifactorial problems

Falls are often caused by a combination of circumstances. Often a problem discussed in the preceding account can be coped with without medical intervention, but in the presence of other disabilities the combined onslaught is more than our elders can manage to overcome. A tendency to falls is increased by poor sight, arthritis, the geography of the home, or often a combination of these, and never simply because of 'old age'. The problem is therefore often a difficult one and in some people the actual cause is never identified. This does not mean that it is not worth looking, because so many of our elders can be helped in many ways even if their falls are not cured, particularly by applying common sense to the environment in which they live. In many of those who have an untreatable tendency to fall the number of falls is reduced and the potential dangers minimized if the layout of their homes is reorganized. However, should they decline to accept this, the risk is theirs to take, as it is ours when we get into our cars or cross a road.

The consequences of falls

Despite the immense catalogue of potential and actual disasters occurring as a result of falls, the majority do not result in actual physical damage. They can nevertheless produce such a fear of falling that an older person will be loath to leave his chair or bed, which in turn may bring about the consequences of immobility.

Fractures frequently follow falls, and there is evidence that some fractures cause falls. This is particularly true in the case of the fractured neck of the femur, when many an elderly person has reported hearing or feeling a loud crack from the hip before actually falling. Over 30,000 people in England and Wales fracture their neck of the femur every year, and it happens to women more than to men, and to older more than to younger people. The subsequent demand on hospital resources is immense since the average length of stay in hospital after a fracture of this nature is four to five weeks for an elderly person.

Treatment of the fractured neck of the femur is aimed at getting the patient mobile as soon as possible to prevent weeks in bed, and the attendant complications. With this purpose in mind the broken neck is often fixed by a nail thrust along the marrow cavity to bridge the fractured region, and sometimes the nail is further fixed to the femur by a plate screwed to the bone, but in some circumstances the femoral head is removed and a new metallic head implanted in its place. These procedures are followed by intensive rehabilitation during which it is easy to forget to ponder on the cause of the original fall, resulting in another fall and fracture after the patient has returned home!

Another common fracture in the elderly occurs at the wrist, especially when falling upon the outstretched hand, and is known as the 'Colles fracture' after the Irish surgeon who first described it in the last century. It is treated by putting the arm in a plaster cast and is often followed by a course of physiotherapy. Again one should try to discover the cause of the fall which precipitated the fracture.

The subdural haematoma, which is mentioned in Chapter 13, is a more uncommon sequel of falling but is important since its effects may be delayed until long after the original injury.

It is well known that older bones break more easily than younger ones because they become brittle due to loss of bone substance Hormones play a part in causing this, as is most commonly shown after the menopause when women's bones begin to become osteoporotic (the bones become thinner). An excess of steroid hormones from the adrenal gland may also exaggerate or cause osteoporosis, as may the prescription of steroid drugs when given to treat other medical conditions such as asthma or rheumatoid arthritis. As well as fracture of long bones, as in the femoral neck and the Colles fracture, bones at other sites may be affected by osteoporosis, resulting in fractures For example, one or more of the vertebrae in the spine may collapse, producing a crush fracture which causes back pain radiating round the trunk, since the nerves which pass round the trunk become compressed.

Management of osteoporosis is controversial but any resulting fractures require treating in the normal way. Some authorities

advocate the use of calcium and/or vitamins and/or hormone treatment but in general there seems little one can do to reverse the changes in the bones, unless it is possible to remedy an underlying medical condition.

Falls are a common problem experienced by our elders, but it should be apparent from the foregoing account that they should never be accepted as a natural concomitant of ageing. Medical assessment and subsequent intervention can usually result in significant benefit, with either cure of the underlying cause, reduction in the number of falls, a lessening of the potential injury from a fall, or, ideally, a combination of these factors.

16 Incontinence

Urinary incontinence

The control of bladder function relies upon a number of reflexes between the bladder and the spinal cord and also upon the development of the ability to consciously override these when it is inappropriate to pass urine, as occurs when waiting until it is possible to get to a toilet. Filling of the bladder not only triggers off these reflexes but also awakens the consciousness to the need to void urine, allowing us to prevent the reflex passing of urine, although conscious control of bladder function can be impaired by factors such as emotional stress.

There is a high level of incontinence in hospitalized elderly people, and estimates varying between about a quarter and a half have been quoted for the number of incontinent geriatric inpatients. This does not mean that the same is true in the community, since incontinent people tend to be concentrated in hospital.

The causes of incontinence include urinary tract infections, changes in the structure and function of the bladder and pelvic muscles, diseases of the brain and spinal cord, and lack of social awareness of the need to control micturition, as happens in some confused people.

The two parts of the urinary tract which most commonly get infected are the kidney and the bladder. Kidney infection can spread to the bladder causing cystitis (another word for bladder infection), but this more often occurs without the kidney being involved. It is also possible for cystitis, especially if recurrent, to lead to kidney infection.

Cystitis used to be considered one of the commonest causes of incontinence, particularly since the infection caused inflammation to an area at the base of the bladder known as the trigone, which is

a very sensitive part of the bladder wall. We now realize that the question is more complicated than this, and it is difficult to be certain in individual cases whether infection causes the incontinence, or whether infection more frequently occurs in incontinent people. A severe infection can make the bladder so irritable, however, that voluntary control is overcome. Urinary tract infections are common in women, and this is sometimes attributed to the short female urethra (the tube conveying urine from the bladder to outside the body) compared to that in the male.

The symptoms of cystitis should therefore be looked for whenever one of our elders becomes incontinent; the most prominent of these are discomfort or a burning sensation when passing urine, the need to get to the toilet quickly, and having to empty the bladder more frequently than usual.

Sometimes there is a predisposing cause for a urinary tract infection such as a stone in the bladder, or a small outpouching of the bladder wall known as a diverticulum, which allows a pool of relatively stagnant urine to become a growing medium for bacteria. In patients with frequent urinary tract infections such a cause must be looked for. Treatment of the infection involves remedying any underlying cause, as well as administering appropriate antibiotics to kill the bacteria. Antiseptic agents may also be used in appropriate circumstances, as well as pharmacological preparations which alter the degree of acidity of the urine, making it difficult for the bacteria to grow.

An abnormal mass in the pelvis can interfere with bladder function, possibly by distorting the normal relationship of the bladder outlet to the urethra. This is seen in younger women when they become pregnant, and in these circumstances the mass is of course the growing womb. In our elders a fairly common mass is a rectum full of faeces, occurring in someone with gross constipation (the rectum is part of the large bowel which lies in the pelvis). This condition is referred to as faecal impaction and can be diagnosed by feeling inside the rectum with a gloved finger.

Stress incontinence is a condition of women in which there is a leakage of urine from the bladder caused by activities like coughing, sneezing, or laughing; it is commoner in younger than older

women and the mechanism is not really understood. When one comes upon it in the elderly female it is often associated with a degree of prolapse of the womb, which can usually be treated by supporting the womb in its normal position with a ring pessary (a large ring inserted round the neck of the womb), although surgery is sometimes necessary.

After the menopause in women a condition described as senile vaginitis can occur as less oestrogens, the female hormones, are secreted into the circulation, resulting in atrophy of the wall of the vagina. This is usually associated with a discharge, and surprisingly impairment of bladder function may also occur as the base of the bladder is sometimes affected too. Treating the vaginitis with local hormone creams, and sometimes oestrogens by mouth, will remedy both the vaginal and the urinary symptoms.

Having read above the causes of incontinence which affect predominantly women, female readers can now take heart that an enlarged prostate gland is a condition suffered only by men. It is so common that it goes a long way to balancing the books between the two sexes as far as causes of incontinence are concerned. The prostate is a chestnut-sized gland surrounding the beginning of the male urethra which, as it gets larger, can encroach upon the lumen (the hole down the middle) of the urethra and cause partial obstruction, which means that the bladder is not completely emptied and semi-stagnant urine accumulates which is more susceptible to infection. If the obstruction is severe, so much urine may be dammed back that the bladder is forced to enlarge until it can no longer grow any bigger. When this state is reached it starts to overflow, producing a continual dribble of urine, known as overflow incontinence. Prostatic hypertrophy, as it is called, can often be diagnosed by assessing the size of the prostate gland with a gloved finger inserted into the rectum and feeling the size of the gland through the rectal wall. Special X-rays are often needed to confirm the diagnosis.

The symptoms include difficulty in starting to pass water, a stream with poor strength, and often the need to pass urine more frequently than before, which can be especially troublesome at night.

Although it is usually a benign (non-malignant) condition, enlargement of the prostate can occasionally be caused by cancer; however, this is rare in comparison to the vast number of cases of benign enlargement.

In fit elderly men able to withstand operation, surgical removal of the gland is the treatment usually recommended, and this used to be done through the abdomen by making a cut in the abdominal wall. In suitable cases this operation is now increasingly being performed through the urethra, in a way that is reminiscent of the 'rebore' in a car engine, by reaming or coring out the obstructed lumen.

A very frail person who is unable to undergo surgery can be treated with an in-dwelling catheter; this is a tube passing to the outside from the bladder where it is secured by inflating a small balloon until it is too large to pass down the urethra The catheter should preferably be attached to a discreetly hidden urine collecting bag, rather than the system still used on occasions which results in the catheter and bag trailing unaesthetically on the floor. There are many bags available which strap inconspicuously on to the thigh. Choice of bag system is important, since in some types the capacity of the bag is small, resulting in the need for frequent emptying. Another point to bear in mind with the advent of new materials used in making catheters is that there are now on the market many which require changing less frequently than before.

Neurological abnormalities leading to incontinence are many and complex, ranging from lesions in the brain to damage to the spinal cord and the nerves.

Damage to the front end of the brain, for example from a stroke or a tumour, can result in loss of the ability to control the bladder contractions which occur when it is filling up with urine It is often associated with a small bladder capacity, and the bladder itself commonly becomes more than usually excitable. The ability to sense bladder fullness is maintained, and this together with the hypersensitivity of the bladder leads to a feeling of urgency in needing to void the urine, often with the loss of control before a bedpan can be brought or the toilet reached. This is responsible

for the incontinence of many of our elder and needs sympathetic understanding.

Other neurological lesions can result in a bladder without sensation, which gradually fills and empties itself incompletely from time to time, and often happens in people with spinal cord damage. Syphilis, a venereal disease, and occasionally diabetes may produce a different set of circumstances where the patient, also unaware that his bladder is full, allows it to overdistend until it can enlarge no more and dribbling overflow incontinence occurs. In addition, severely confused patients often lose their voluntary bladder control so that it reverts to emptying itself through the reflexes which work at the level of the spinal cord.

As is the case in nearly every complaint of our elders, drugs can also be incriminated as a cause of incontinence in many people. This can be the result of night sedation, especially with barbiturates, which cause them to sleep through the need to pass their water. The brain's receptiveness to all stimuli may be considerably diminished and many an old person with wet beds has been restored to normal when the sleeping tablets were changed to a less potent variety, or better still discontinued altogether.

There are other drugs which make it difficult to empty the bladder, thus precipitating retention of urine with overflow incontinence. This is a particular danger if the person involved has another potential cause of obstruction, such as a large prostate gland. Diuretics must also be suspected if an old person is reported as being incontinent; they are especially likely to be a factor in the case of the more potent diuretics like frusemide, which causes a full bladder by encouraging the kidneys to rapidly produce a large quantity of urine, precipitating retention of urine in the bladder or urgency of micturition.

There are of course many people in whom no obvious side-effects result from the prescription of these and other drugs. Although this is sometimes because the drugs are just not taken, many people genuinely do not get side-effects, but nevertheless drugs should always be suspected as the cause of any health problem until proved otherwise.

The patient's own environment may cause incontinence, for

example when he or she is unable to get to the toilet quickly enough, as often happens in the middle of the night. He is not really incontinent so much as the victim of his environment and possibly other medical problems which impair mobility. Simple measures such as the provision of a commode at the bedside will remedy situations of this kind, and many an old person has been helped in this way.

Treatment of urinary incontinence

The most important aspect of treating incontinence is to look for a remediable underlying condition, such as those already described. If one is found, catheterization should be avoided at all costs since it will almost certainly lead to the introduction of infection into the urine. Care must be taken when waiting for the return of continence to avoid pressure sores, to which wet soggy sheets and clothing may well contribute As a temporary measure rubber tubing can be taped to the penis in men, or a male urinal used, but it is more difficult in women where often frequent toileting is the only answer, besides various types of padding to soak up the wet

If it has been established that the incontinence is not curable, there are various drug treatments which can be tried, and the doctors looking after the patient will decide which type, if any, is appropriate. Many incontinent patients end up with an appliance of one sort or another, drug therapy notwithstanding. Most of these are designed for men and are only suitable in a co-operative person Unfortunately, there are no satisfactory appliances for women and it may be necessary to resort to waterproof pants with absorbent padding to minimize the effects of the incontinence. A waterproof mattress cover may also prove invaluable in these circumstances, as can the local authority's incontinence laundry service, which will remove the burden of washing and drying soiled bed-linen, although there are unfortunately many areas where this facility has not developed. Despite the many limitations, long-term catheterization is the mainstay of treatment in the chronically incontinent person, and the risk of infection introduced into the bladder must be weighed against the benefits of being dry.

It is often better to be dry with a catheter and an inconspicuous thigh bag and living at home than to be wet and lying in an institution.

There is one final point of interest. It is always worth trying to restrict absolutely any fluid intake after about 5 o'clock in the evening in a person who is incontinent at night. If fluids are unrestricted during the rest of the day the person will come to no harm, and the nocturnal incontinence may improve.

In many elderly people a treatable cause of incontinence is found, and the problem remedied. In those where this is not the case, it is usually possible to find ways of lessening the problem and lightening the load on relatives and helpers. Incontinence should never be accepted as inevitable.

Mr Robinson, an 80-year-old former drayman, was taken to his doctor by his son with whom he lived. The problem was continual incontinence, resulting in wet clothes, a wet chair, and a wet bed. Examination showed that he had a large distended bladder and an enlarged prostate gland. This was confirmed by special X-rays. Before becoming incontinent he described symptoms typical of prostatic enlargement, and so he underwent removal of his prostate gland Although he remained incontinent for several weeks after his operation, when all the effects of this had settled down he again became the master of his own stream.

Faecal soiling

Like urinary incontinence, faecal incontinence can pose a major problem in the management of an elderly patient, a resident in an old people's home, or someone living alone or with a relative, and is in many ways more unpleasant than urinary incontinence, but fortunately more often treatable. Despite this it has been estimated that a staggering 45,000 people in England and Wales suffer from it. Soiling of this type may be caused by a local lesion, for example a tumour or inflammation in the colon or rectum (the two main parts of the large bowel), but may be the result of a simpler lesion, for instance faecal impaction or a side-effect of drugs, especially purgatives. Faecal impaction acts as a partial blockage in the bowel, allowing only liquid material past.

As in urinary incontinence, treatment starts with the diagnosis

of the cause. Local lesions may require surgical intervention, but more frequently faecal soiling is found to be due to impaction of faeces within the rectum, or a side-effect of drugs. In these circumstances clearing the bowel with suppositories or enemas or stopping the offending drug will lead to more normal bowel habits. In the case of faecal impaction it may be necessary to prevent constipation recurring by, for instance, including adequate roughage in the diet, often in the form of bran.

In those cases where no cause is discovered the abnormality may well reflect neurological damage of some sort. This can often be treated by deliberately causing constipation, to prevent the faecal soiling, in conjunction with suppositories or enemas perhaps twice weekly to clean out the accumulated faeces before they lead to faecal impaction and the return of soiling. In a way this is a method of producing artificial bowel clearance at convenient and appropriate times.

Mrs Roberts complained to her doctor that her 83-year-old husband had become incontinent of both urine and faeces. The doctor examined her husband but could find nothing significantly wrong except for a rectum loaded with faeces. He arranged for the district nurse to give Mr Roberts an enema, and when the bowel was successfully and completely evacuated the double incontinence resolved. It was then discovered that Mr Roberts had been buying some tablets for his painful arthritis and that these contained a constipating agent. When they were replaced with a different drug his constipation did not recur and his bowel function required no further attention.

Like urinary incontinence, faecal soiling should never be accepted as a normal concomitant of ageing. It is very often possible to eliminate this problem completely, and it warrants full medical appraisal.

17 Problems of communication

As one ages, some of the special senses lose their keenness and many older people are unable to smell, which is sometimes coupled with deterioration in the ability to taste. The appreciation of vibration, such as the sensation induced when a vibrating tuning fork is placed in contact with a bony prominence, also declines in many of our elders and is particularly obvious in the feet and occasionally the knees, although the significance of this is uncertain. Proprioception, or joint position sense, which keeps one informed of the position in space of parts of a limb (for example, it will tell you whether your toe is pointing up or down) may often be reduced, although less commonly so than vibration sense, and can make simple activities like dressing difficult The other sensations such as temperature, touch, and pain are usually unimpaired.

Of all the special senses, sight and hearing are probably the most important, and everyone knows some person whose old age has been dogged by poor vision or deafness. So often accepted as the natural consequence of ageing, these disabilities are often amenable to medical help which can reduce their impact on the quality of life of the affected person if they are reported to the doctor in good time Together with speech, the other major component of communication, they rival mobility in their importance as a bastion of independence. Conditions impairing these three faculties will now be considered in turn, and while reading the following account most readers will be taking their own sight for granted, as they will also their power of speech and the ability to hear when they discuss any of the matters raised with another person. It is hoped that this chapter will emphasize that isolation resulting from impaired vision, hearing, or speech with its attendant problems should be the subject of a serious attempt at remedy or amelioration, despite the

easy acceptance of these disabilities as part of the normal spectrum of diseases of ageing.

Failing sight

A survey a few years ago found that at a conservative estimate about a third of a million old people had visual impairment but had not had an eye examination for at least five years, and in many instances their eyes had never been examined at all Many of these probably only required glasses or alteration of their existing glasses but many others would have been subject to one or more of the conditions discussed in the following account of some of the commoner causes of failing sight in our elders. Although the emphasis will be upon medical conditions this does not imply that all older people have visual deterioration, since there are many whose sight is well preserved.

A cataract in the lens is a common cause of failing sight. The lens is made up of fibres which are continually formed during life, the older ones being found in the centre or nucleus of the lens, which means that it gets thicker as the years advance, partly contributing to the long-sightedness common in elderly people. (The optical explanation for this is too complex for discussion here.) The centre of the lens becomes gradually harder and less transparent, resulting in one form of senile cataract. This process occurs at different rates in different people for reasons that are all ill understood, although heredity probably plays a part. Another type of senile cataract involves the outer part of the lens, and in either type both eyes tend to be affected. There are numerous other causes of cataract, and these include steroid drugs, for example prednisolone taken for asthma, or hydrocortisone applied locally to the eye for specific conditions; diabetes; and other less common conditions such as abnormality of the parathyroid gland.

Different types of cataract need different treatment. The senile type developing in the centre of the lens can be treated in its early stages by changing the glasses and using drops to increase the size of the pupil, thus letting more light into the eye Cataract removal becomes necessary when sight has deteriorated sufficiently to affect

significantly the activities of daily living; it involves removal of the lens, which is why 'pebble' glasses need to be worn afterwards. They are really a replacement lens placed outside the eye to make up for the one removed. These glasses unfortunately make it difficult for the wearer to see properly except when looking straight ahead, as some objects appear distorted at the periphery of the field of vision, causing distress to many old people until they have got used to the effect.

It is interesting to note that many people with a cataract see things rather pinker than they really are, and this is reputed to be the reason why some of the world's great painters, for example Turner, painted many of their masterpieces with a pinkish tinge.

The success of cataract removal relies partly upon the presence of a sound retina which is the light-sensitive layer at the back of the eyeball responsible for conveying what the eye sees to the brain. The retina is not always normal, and it may not become apparent until after the operation that the retina is also damaged, as a large cataract can prevent the doctor inspecting the state of the retina pre-operatively.

One of the commonest causes of retinal damage is a condition known as macular degeneration. This is due to impairment of the blood supply to a particularly sensitive part of the retina called the macula, and leads to a defect in the centre of the visual field but rarely if ever to complete blindness. Other conditions which affect the retina include diabetes and high blood pressure. Unfortunately, there is little one can do medically to remedy these conditions except treat any underlying cause in order to minimize the damage, although the provision of supportive measures may be helpful. An exception is one type of diabetic retinal damage, which can sometimes be helped by special treatment.

'Floaters' are another common phenomenon experienced by elderly people and can be disturbing to both the sufferers and their relatives. Generally speaking they are of no significance and do not significantly impair vision, and are really small particles floating across the main chamber of the eyeball They are included here since they can occasionally be the earliest sign of a more serious condition and should therefore be reported to the doctor so that

this can be checked. In most cases, however, they are not a cause for alarm.

Glaucoma is not specifically a condition of the elderly but merits consideration because it is present in many people entering old age. It is caused by a rise in the pressure within the eyeball; there is more than one reason for this and the mechanisms are not completely understood. Glaucoma can arise suddenly, when the patient will complain of a very painful eye, sickness, and sometimes blurring of vision. This is an urgent indication requiring the careful administration of special eye-drops and sometimes injections. In many cases an operation on the eye is eventually needed to prevent a recurrence by aiding the drainage out of the eyeball of the fluid which it contains, and in this way lowering the pressure.

Glaucoma can also be found by chance during a visit to the optician or when the patient goes to his doctor because of failing sight. Under these circumstances some sight has often already been lost and treatment is aimed at preventing further deterioration; this can often be managed with drops and tablets, but if the visual defect continues to worsen an operation will probably be necessary.

Another common condition causing difficulty in seeing occurs after a stroke, when it appears as though there is no sight in one eye. This is not really the case, as is explained in the chapter on strokes (page 200).

A summary of the provisions set out by the National Health Service for the care of sight is contained in leaflet NHS 6 which is available at post offices.

Mrs Davies was noted by her family to be becoming more and more depressed. Eventually it became obvious that she was having great difficulty in seeing, and transpired that assuming her failing sight was a natural result of ageing, she was just waiting to become completely blind. This state of affairs was causing her great despair.

Her daughter eventually persuaded her to see an optician, who discovered that she had cataracts and advised her to see her doctor. He referred her to an eye specialist, and shortly Mrs Davies had her worst cataract removed. The effect on her was dramatic, and her whole outlook on life changed for the better. The only regret she expressed was that she had not gone to seek help earlier.

Deafness

Although it is possible to have completely adequate hearing throughout the normal life span, most people lose some appreciation of higher tones as they grow older, but this interferes little with normal conversation. Deafness, however, is common among the elderly and usually affects men more than women. It can be caused by conditions of either the middle or the inner ear, although an excess of wax in the outer ear is occasionally responsible. Most commonly it is the inner ear mechanism that is predominantly affected, producing what is called 'nerve deafness', rather than the 'conductive deafness' produced by diseases of the bones in the middle ear which transmit sounds across the middle ear cavity to the inner ear. Although both types of hearing loss are very often present together, conductive deafness must be particularly suspected when only one ear is involved.

Existing middle ear disease can often be coped with, until nerve deafness develops as well. Often a similar level of nerve deafness will not matter in another individual whose middle ear is normal, although there comes a point when the deafness, whichever sort, is a great disability in its own right. Among the other predisposing factors are prolonged exposure to noise and disease of the blood-vessels.

Deafness is most often treated by trying to amplify the sounds by means of a hearing aid, but unfortunately this is often unsatisfactory for a number of reasons: batteries run out; the wearer omits – sometimes deliberately – to switch it on; and some of our elders dislike wearing an aid, especially since people tend to ridicule those who are known to be deaf, while they will accept the spectacle-wearer as normal. Hearing aids also demand manual dexterity which arthritic fingers cannot supply and, unlike the ear, hearing aids are not selective. Although normal hearing allows one to listen to one particular sound, such as speech, against a background of many others, hearing aids amplify all the extraneous noises too, and occasionally add some of their own! Despite the disadvantages and difficulties experienced by some elderly people most of those with deafness can be helped, at least in part, with an

aid, providing it is used in a sensible way by both the wearer and those around him.

Difficulty with speaking

Speech difficulties are unfortunately often very difficult to correct. They are most commonly the results of a stroke and take the form of difficulty in pronouncing words, resulting in slurred speech, or difficulty in finding the right word to use. In the former individual words are mispronounced because of abnormalities affecting the way in which the vocal cords and tongue work, that is it is a mechanical problem In the latter a person may know exactly what he wishes to say but cannot say it, for example he may call a pencil 'something you write with' because he cannot say the word 'pencil'. On occasions much simpler matters may affect speech, and an example of this is the ill-fitting denture.

Speech difficulties can lead to considerable frustration and be mistaken for mental disease. An inability to make oneself understood often gives rise to depression and lack of motivation, impairing rehabilitation in general. The speech therapist is trained to assess the type of speech problem and is also skilled in the management of some of these difficulties, often being able to show friends or relatives how to help the patient if his condition is amenable to treatment. If it does not respond, she will advise about the appropriateness of alternative means of communication in an attempt to minimize the disability.

Other conditions affecting speech are legion They range from Parkinsonism (page 159), abnormalities of the cerebellum (page 164), psychiatric disease (page 104), and thyroid gland malfunction (page 142).

General approaches to the management of communication problems

A lot can be contributed to the management of people with communication difficulties simply by the use of common sense. Blind people have no idea who or what is around them unless they are

told or are able to touch something, so it is often helpful for them if someone they do not know well who is speaking to them identifies himself, particularly in an institution where staff change between shifts. It is also important not to assume that blindness itself leads to total dependence, as we could probably dress and feed ourselves in the dark or with our eyes closed, and many older blind or partially sighted people live independently in their own homes. Often it is more difficult to convince well-intentioned relatives than our elders that they do not need to live in sheltered accommodation.

People with failing or non-existent vision can be helped by registering as partially sighted or blind, whichever is appropriate, since they are eligible for certain financial and other benefits. This is best done with the help of the general practitioner who would probably first refer them for a specialist opinion Many people entitled to do so have not registered, sometimes because of pride, but also because of lack of knowledge of the facilities.

Deaf people often feel left out and sometimes this isolation turns into a persecution complex, when they believe everybody is talking about them. Lip-reading can help overcome this but only if people speak to them face to face, and it also needs reasonable sight, which may be impaired in an older person. Blind people often seem to develop a keener sensation of touch or hearing, but deafness is not overcome in this way.

The old-fashioned trumpet-shaped hearing aid has been relegated largely to theatrical comedy. This is in some ways unfortunate as many people who cannot manage or cannot tolerate an electrical aid would be helped by one of these. In particular they produce less distortion than many modern aids, and extrinsic noises intrude less. There are also other aids available, for example electrical amplification sets for use with television and the telephone which are a boon to the lucky few who have access to them, since they help to minimize the degree of isolation thrust upon the deaf. The Royal National Institute for the Deaf has pioneered the use of many other aids, for instance flashing door alarms rather than doorbells, and a little ingenuity will often produce similar devices to overcome other problems

Trained volunteers, particularly those relatives or friends who

have a special relationship with the person involved, can help people with speech difficulties. Collaboration with a trained speech therapist can lead to an understanding of what is needed and ensure that much more is made available to help remedy certain types of speech defect than the Health Service can provide.

Finally, it should be remembered that to have one communication barrier is bad enough, but to have more than one can make the afflicted person almost a prisoner within himself. It therefore behoves us all to treat with sympathy and understanding elderly people who have these disabilities, even though it is easier to mock or be irritated by them.

18 Disorders of nutrition

Much of the present medical and lay interest in food concerns the possible relationship between certain dietary factors and disease, particularly that which possibly exists between animal fat (including cholesterol) and 'hardening of the arteries', with particular reference to heart attacks and angina pectoris. There is also concern about the consequences of obesity, which is one of the commonest types of malnutrition in the Western world, since high blood pressure and diabetes mellitus can be caused or aggravated by being overweight. More specifically among our elders an inadequate intake of food, especially protein and certain vitamins and minerals, can also lead to ill health. It is important to realize that at any age eating too much of the wrong things can lead to illness just as can not eating enough of the right things.

Obesity

It is well known that a diet containing too many calories can shorten life. This has been shown in animal experiments, and statistical analysis of information collected by life insurance companies has confirmed that being overweight is associated with a reduced life span. Obesity increases the wear and tear on certain joints, is associated with a more than average risk of suffering from a respiratory tract infection, for example bronchitis and pneumonia, and of having varicose veins, and is linked to a greater chance of suffering from hardening of the arteries, although it is difficult to know whether the latter relates to the obesity itself or the excessive intake of animal fats which people with the condition often consume. Diabetes and high blood pressure will each be described separately since they merit more detailed consideration as two common conditions encountered in the elderly.

Diabetes mellitus

This condition is so named because in the days when it was part of a doctor's duty to taste his patients' urine, it was found to be sweet-tasting in people with this disease. Diabetes diagnosed in later life and often associated with obesity is usually of the type known as maturity onset diabetes, and insulin injections are not often required, treatment involving weight reduction in those who are obese, and a diet and tablets, as described later. A deficiency of insulin, which is normally produced in the pancreas (a gland in the abdomen), results in a rise in blood sugar and other abnormalities of carbohydrate and fat metabolism.

The classical symptoms of severe diabetes are thirst, the production of large volumes of urine, often requiring more visits to the toilet than usual, especially at night, and weight loss. There are many other causes of excessive urine production or frequency of micturition so it is important to think of these as well before diagnosing diabetes. The loss of water in the urine leads to dehydration, and certain body salts are lost too. A person with diabetes may also experience tiredness and weakness, and itching involving the genitalia is a common experience, especially in women, in whom it is often caused by a skin infection with a yeast organism producing a condition called thrush In many elderly people the disease is only diagnosed when they attend the doctor with complications and are found to have sugar in the urine.

Diabetes often affects sight, for instance by damaging the retina, but it can also aggravate cataracts in the lens. Kidney damage may also occur but rarely causes death since it progresses slowly compared to some of the other complications. The nerves may be affected, although the processes involved are little understood, leading to weakness of the muscles supplied by the affected nerve as well as loss of sensation. If the latter affects pain and temperature sensation the diabetic's foot can easily become damaged, since a person with diabetes who has impaired sensation may continue to allow damage to occur when a normal person would stop because of pain. This, together with the poor circulation which is often present, and an increased susceptibility to infection, can result in badly damaged feet which may need amputation,

although this is not as often necessary in maturity onset diabetes as in that requiring insulin.

Abnormalities of the nerves controlling the autonomic nervous system, that is the part of the nervous system which regulates the bowels, bladder, and sweat glands, etc. without our conscious control, may cause bowel and bladder disturbance and postural hypotension (see Chapter 15). Hardening of the arteries to the heart is accelerated in many people with diabetes, and the consequent heart disease is probably responsible for more of them dying than any other cause, particularly in middle age.

Diabetes is diagnosed by finding sugar in the urine or too high a level of glucose in the blood, and is often confirmed by measuring the level of glucose in the blood at certain times after a meal or by giving the person a large dose of glucose in the form of a drink.

People with mild diabetes who are overweight can often be treated by weight reduction and restricting the amount of carbohydrate in their diet to about 100 g a day, but this is often difficult in the elderly since eating what they fancy may be one of the few pleasures left to them. If diet alone is inadequate to control a maturity onset diabetic it will be necessary to add tablets to the treatment. One kind, known as sulphonylureas, stimulate insulin production from the pancreas while others, called biguanides, work without affecting insulin production Certain members of the former group of drugs should not be given to older people if possible because they are removed from the body by the kidneys, and if these are not working properly too much of the drug builds up in the blood causing the sugar level to fall too low. The biguanides also have their particular disadvantages but are often used in combination with a sulphonylurea. In some older people the diabetes cannot be controlled by diet and/or drugs and requires insulin, of which there are many different types, and it is the doctor's job to match a particular regime to an individual patient's needs, taking into account the practical difficulties of administering insulin to an older person.

In the longer term as well as regular monitoring of their sugar levels people with diabetes need particular care taken of their feet by a trained chiropodist, and also of their eyes; it is also important

to watch for the signs of diabetic coma. If the blood sugar level rises too high the normal diabetic symptoms may or may not be exaggerated and confusion and drowsiness usually occur before coma ensues, while too low a level produces sweating, paleness, and shakiness, and the person may complain of hunger, weakness, and palpitations as well as exhibiting behavioural changes before passing into a coma Hypoglycaemia, as the latter is called, should be suspected especially if he or she is taking insulin or drugs and has missed a meal or had unaccustomed exercise, but both these situations are emergencies requiring immediate action, and medical help must be summoned if drowsiness or unconsciousness arises

The sugar level in the majority of elderly people with diabetes is relatively easily controlled, and most of our elders with this condition live their life little troubled by it. The British Diabetic Association produces helpful pamphlets and will give advice on problems to their members.

High blood pressure

It is very difficult to decide when blood pressure is too high, especially in people over the age of 65. In general doctors accept that blood pressure may be higher in older people without necessarily causing the problems associated with a similar level in younger people, but a very high blood pressure in elderly people is, however, just as much an emergency as in somebody many years their junior.

Many medical conditions can cause a high blood pressure, but with the exception of obesity most of these conditions are uncommon, and many people are found to be hypertensive (having too high a blood pressure) who are not overweight. Despite this, when obesity and high blood pressure occur together weight reduction will usually lower the blood pressure, often sufficiently to avoid the need for medical treatment. A blood pressure that is too high can cause damage to blood-vessels, leading, for instance, to strokes and heart attacks, as well as causing heart failure, and, just as in diabetes, the eye and the kidney may be affected.

When an elderly person is found to have hypertension the doctor has to confirm that the blood pressure really is high and that it is not just raised because of the stress of being in his surgery, which is the reason why it is usual not to treat high blood pressure until several measurements have been made on different occasions. Once the diagnosis has been established it is necessary to decide if there is a treatable underlying cause, and then to treat the elevated blood pressure if, as is usually the case, no such underlying cause can be found. Apart from weight reduction in a fat person, it is necessary to resort to drugs to lower blood pressure, and a variety are available, but a balance has to be struck between side-effects of the drugs and the benefits of lowering the blood pressure. There are many preparations ranging from diuretic drugs to those known as beta-blockers which reduce the heart rate. However, careful thought is always needed before treating high blood pressure in an elderly person unless there are already signs of damage such as heart failure since all drugs have their side-effects and the benefit of treatment in the elderly is more uncertain than in young or middle-aged people. It is usual, however, to find a treatment regime that is tolerable to the patient, and most sufferers with high blood pressure lead normal daily lives, especially elderly people with only mild hypertension. Unfortunately, many people do not take their tablets unless they actually have symptoms, and in many cases such as in the treatment of hypertension and diabetes, where the aim is prevention of consequences rather than amelioration of existing symptoms, the drugs are often neglected.

Mr John Dempsey, a 72-year-old retired railway-worker, was admitted to hospital after a small stroke. Six weeks later he had almost completely recovered and went back to his own home, but during his stay in hospital his blood pressure was found to be high, and had remained elevated. His general practitioner had also noticed that it had been recorded as being higher than average six years previously, but that at that time Mr Dempsey had declined any treatment. Since he was now considerably overweight he was advised to diet while in hospital and also after his discharge, and successfully managed to lose 29 kilograms. His blood pressure decreased slowly to 'normal' levels and no further treatment was needed. Seven years later he was still alive and well with a slightly high blood pressure when he reattended the hospital clinic for another unrelated condition.

Nutritional deficiencies

Social and economic factors affect the diet of the elderly more than that of younger people, with the exception of the very poor. It has been recommended that men over 65 should have a daily calorie intake of some 2,000 to 2,500 kcals, and women around 2,000 kcals, with a protein requirement varying between approximately 50 and 60 g daily. In addition essential vitamins and minerals are required, as are fat, roughage, and water. Many surveys have shown that a large percentage of our elders do not eat an adequate diet but since many individuals in this age group are also very obese it is obvious that an alarmingly large number of people over the age of 65 have bad eating habits.

In one study of the nutritional status of old people admitted to hospital in Britain, it was found that about one person in twenty-five had protein deficiency severe enough to cause swelling of the legs. Protein is expensive and needs more preparation than foods rich in carbohydrates, and it is not surprising that an older person, especially if cooking for himself, is tempted to neglect this in favour of more easily prepared, less expensive, but nutritionally poorer convenience foods When one considers that dietary protein is broken down to form the building blocks with which the body tissues are replaced and renewed it is easy to understand the importance of including an adequate amount in the daily diet. In no age group is this more important than in our elders.

Many elderly people have lowish stores of iron in their body, and anaemia caused by iron deficiency is not uncommonly discovered as the major or a contributory cause of disease in an older person who becomes ill. At times it is tempting to ascribe this to dietary deficiency but it is difficult to be sure and very often a site of blood loss in the body, for instance in the bowel, is discovered, although this may on occasions not be immediately apparent As well as being necessary to allow the marrow to produce normal red blood cells iron, in common with most other vitamins and minerals, is essential for other body tissues too. Changes in the skin, nails, and hair will be noted in individuals suffering from iron deficiency, and there are other changes not apparent on external scrutiny.

Vitamin deficiencies of a dietary nature often occur together. Vitamin C deficiency is reported in many studies of the nutritional status of our elders, both those living at home and in institutions, and inadequate intake of vitamin C (or ascorbic acid as it is called) leads to changes in the blood including fragility of the blood-vessels themselves, and to abnormalities of the skin and some body hairs. The level of vitamin C in white blood cells rather than the blood itself must be measured in order to establish a deficiency. Lack of vitamin B_{12}, which may occur because of impaired absorption from the bowel rather than just an inadequate dietary intake, causes anaemia and damage to the nerves and spinal cord, as well as being a cause of confusion (see Chapter 13). Folic acid is another vitamin which is necessary to allow blood cells to form normally, and a deficiency of vitamin D leads in particular to disorders of the bones, with softening, called osteomalacia when it occurs in our elders and rickets in young children.

It should be noted that disease due to deficiency of vitamins or minerals in the body may be caused by inadequate dietary intake, abnormalities of the bowel leading to poor absorption even though the vitamins are present in the diet, or a combination of both these factors. Luckily, once diagnosed, most of the diseases arising from vitamin deficiency are easily remedied with appropriate preparations to make up the deficit.

Osteoporosis, or thinning of the bones, which was mentioned in Chapter 15 as being a contributory factor to certain fractures, especially a fracture of the neck of the femur, occurs in about a third of women aged 60 or over, and in many men too It is possible that calcium deficiency may play a part in producing this condition, but the evidence is controversial. Osteomalacia, or softening of the bones, may occur together with osteoporosis, and it can be difficult to sort out what is actually the problem in an individual patient. Increasing the calcium intake by giving additional calcium in the diet, and even vitamin D which improves calcium absorption from the bowel, rarely seems to prevent or cure osteoporosis but is usually very effective in the case of osteomalacia and brings considerable relief from the symptoms.

Fibre is the new term for roughage. As our diets have come to

contain more highly refined and purified foods the roughage content has become increasingly reduced and there is a lot of evidence that this lack of fibre has caused an increase in certain conditions. Probably the commonest of these is constipation and it is a major complaint of many older people. Fibre increases the size of the bowel motions, making them bulkier, and bulky stools pass through the bowel more quickly. The longer a stool is in the large bowel the more water is absorbed from it by the lining of the bowel and the smaller, drier, and harder it becomes, leading to greater difficulty in its evacuation, and thus often resulting in constipation.

Diverticular disease of the colon is a condition where small outpouchings are formed from the bowel wall. These are called diverticulae, and if they become full of bowel residues they may become infected and inflamed, producing the condition known as diverticulitis. Many people develop diverticular disease as they grow older, but by no means all of them suffer from diverticulitis. Diets low in fibre may lead to the development of higher pressures in the large bowel, possibly in order to expel a constipated stool, and this increase in pressure may be responsible for the small 'blow-outs' of the diverticulae. The increased pressure may also lead to the passage of faecal material into the diverticulae and thus play a part in the production of diverticulitis. Increasing the fibre content of the diet, for instance by including bran, helps people with these conditions.

Reduction of fibre in the diet has also been linked with tumours of the large bowel and with the formation of gall stones. These last two correlations are not definite, and fuller investigation of the potential relationship is proceeding. Less convincing, but possible, is evidence linking the formation of haemorrhoids (piles), varicose veins, and hiatus hernia (a 'rupture' of the diaphragm allowing part of the stomach into the chest) with dietary fibre deficiency.

The simplest means of correcting a dietary fibre deficiency is to eat fresh fruit and vegetables and wholemeal bread, not to mention potatoes in their jackets The addition of bran to the diet, following the doctor's instructions, is also often a useful adjunct to these measures and can result in a significant reduction in the symptoms

experienced as a result of having diseases caused by a dietary fibre deficiency.

Some aspects of malnutrition in the elderly are commoner than others, and in the Western world the consequences of obesity and lack of dietary fibre occur more commonly than dietary deficiencies. Old age, poverty, and an inadequate diet are often linked together and are the subject of much discussion, while obesity and lack of roughage, on the other hand, are often just accepted as normal. The health of the elderly in general could probably be as effectively improved by education and assistance in these latter fields as by searching for and correcting dietary deficiencies, since nutritional disorders, once discovered, are usually relatively simple to correct. Prevention of disease, however, is always better than treatment, and effective health education, better pensions (see Chapter 7), and assistance when necessary with the physical problems of shopping and preparing food, would go a long way to preventing some of the nutritional problems of our elders.

19 The effects of cold

Most warm-blooded creatures have an in-built mechanism to keep their body temperature at a particular level, that at which the complex biochemical and physiological processes sustaining life function most efficiently, and if their body temperature falls much below this problems may ensue. In human beings the normal temperature is 37°C (98.4°F) when measured orally, which is usually an adequate procedure, although it does not always reflect the body's core temperature, for instance it may appear to be lower when a person is breathing through the mouth in a cool environment. The same is true of the thermometer reading when it is taken in the armpit, because the skin can be colder than the rest of the body. Whenever a low body temperature is suspected the thermometer has to be placed in the rectum, or else used to measure the temperature of a freshly passed sample of urine. Normal thermometers do not read low enough to accurately measure the low body temperature sometimes found in our elders, and so a special 'low-reading' thermometer is used instead. When the body temperature falls below 35°C (95°F) the condition 'hypothermia' is diagnosed; this is not uncommon in the elderly, especially if they have thyroid gland disorders, but can also occur in others subject to low temperatures, for example hill-walkers and long-distance swimmers.

Every winter many of our elders are found unconscious or semi-unconscious in their homes as a result of hypothermia. It has been estimated that at least as many as 4,000 people over 65 years of age are admitted to hospital in the winter because of hypothermia, and that many more are at risk of developing this condition while in their own homes.

An elder may develop hypothermia for one of a number of

reasons, but in many cases there will be more than one underlying factor. We all have complex temperature-regulating mechanisms, and shivering is a well-known part of this – it really represents repeated frequent muscle contractions, and is a mechanism to generate heat – as is the pattern of blood flow within the body. It is a very complicated system which also involves special parts of the brain and if it becomes impaired, as it does in some people as they age, hypothermia is a potential risk.

Other common factors involved in the risk of becoming hypothermic lie in the home environment, for example poor insulation of houses, inadequate clothing, and an inability to pay for adequate heating are common in cases where older people have been discovered suffering from hypothermia.

Certain drugs are known to lower the body temperature and increase or aggravate any tendency an older person may have to develop hypothermia. Chlorpromazine (also known as largactil) is one drug which is commonly implicated; it is usually used as a sedative or to treat certain psychiatric conditions but there are many more drugs which are known to be associated with an abnormally low body temperature. These include some of the anti-depressants and some sleeping tablets (especially barbiturates). Those that cause sedation can lead to hypothermia just by decreasing the level of consciousness, but they can also cause the temperature to become lowered in other ways.

Myxoedema or hypothyroidism, that is an inadequate functioning of the thyroid gland, is a relatively common undiagnosed condition in older people; it affects the body's metabolism and so can lead to a low temperature. People who are myxoedematous often gain weight, develop coarse skin and hair, complain of constipation, are intolerant of the cold, usually have a slow pulse rate and abnormal reflexes, and can become confused As well as being at risk of coma because of a low body temperature, they can lapse into unconsciousness on account of the myxoedema itself. All our elders who become hypothermic have to be screened to exclude the possibility of myxoedema as well as ensuring that they are not taking any of the drugs that are known to lower the body's temperature.

One cold Monday morning in January Mrs Jackson's home help arrived to carry out her usual tasks and discovered that Mrs Jackson was lying motionless on the bedroom floor. The house, as usual, was cold and Mrs Jackson was wearing only a thin nightdress. Her doctor was called immediately and at first thought that she was dead, but was able to feel a very faint slow pulse. She was extremely cold to touch and he had her admitted to hospital with a suspected diagnosis of hypothermia. This was confirmed in the Casualty Department where the rectal temperature was found to be only 30°C Fortunately, Mrs Jackson survived this illness and made a full recovery, unlike many others No evidence could be found for a particular underlying cause, and when she eventually left hospital she went to live in a special old person's bungalow. Supervision of her heating and clothing by her relatives in the following winter avoided any further episodes of hypothermia.

The most obvious sign of this condition is the low body temperature itself. The skin feels extremely cold, even icy, and may take on a pale waxy appearance so that in a severe case it is possible to be misled into thinking the person is dead since he or she is usually in a coma and often apparently lifeless Before this stage is reached a vicious circle is set up as the increasing cold leads to apathy which in turn produces a disinterest or inability to do anything about rectifying the situation.

A person developing hypothermia may become confused, have slow reflexes which can eventually totally disappear, and have a very slow pulse rate and low blood pressure. Slow shallow respiration, at times almost imperceptible, is also a feature and the kidneys may stop functioning normally; other complications include cardiac arrest, dilatation of the stomach, inflammation of the pancreas, and pneumonia. There are also changes in the blood, some of the hormones, and the body's metabolic reactions, so it can be appreciated that a low body temperature will produce widespread damage in many body systems, and many people who develop severe hypothermia do not survive.

All people in whom the body temperature falls below 35°C should probably be admitted to hospital This is not just to treat the hypothermia itself but also to check that there is not an underlying cause which would result in the temperature falling even further, or another episode of hypothermia following at a later date. It is a serious medical emergency.

Elderly people who are hypothermic are best treated by a slow, gentle rewarming, while their body temperature is measured rectally, aiming to raise their temperature by only 0.5°C an hour, often using only blankets and a warm room, since if the temperature rises too quickly the blood pressure may fall and other complications can develop. The heart's action is monitored during treatment, since serious disturbances of heart rhythm can occur, sometimes leading to a cardiac arrest. As with all unconscious patients it is necessary to take precautions against the possibility of the content of the stomach being regurgitated or vomited into the throat, and from there inhaled into the lungs, which can cause pneumonia. Attention has to be given to the fluid and salts in the body, and antibiotics are commonly prescribed because infection, especially pneumonia, may be present without any outward sign.

The reader will observe that what is at first sight a simple problem, often preventable by simple practical measures, is in reality a complicated and life-threatening emergency for many of our elders. It behoves us all to ensure as best we can that as many as possible of the elderly known to us to be at risk are reported to the appropriate authority. This may often be difficult, especially when one wishes to respect the desires of many of them to retain their independence.

20 Strokes

Strokes are occurring more frequently in our elders and an increasing number of patients are being admitted to hospital with this condition, while relatives also look after a good many patients with strokes. Those of us who look after them frequently easily become forgetful of their problems and take for granted so much that is of importance to them. When coming into contact with a patient who has had a stroke we should all think how we should feel if in their position and try to enable them to maintain as much dignity as possible, and at all times keep an understanding of the emotional turmoil they are going through.

A stroke is often labelled a 'c.v.a.' by doctors (this is medical shorthand for a 'cerebro-vascular accident', which is the technical term for a stroke), since in most cases the blood supply to an area of the brain has become compromised, or a haemorrhage into the brain substance has occurred. The result is often complete or partial paralysis of the limbs of the other side of the body, since for some strange reason nature has allowed the nerve fibres from one half of the brain to cross over and serve the opposite side. As well as paralysis, a stroke often results in difficulty in seeing, in disturbance of bowel and bladder function, and, in some cases, confusion.

About two-thirds of people with a stroke are admitted to hospital where they embark on a treatment programme that starts off with acute therapy while they are struggling for survival and is followed by rehabilitation and then in most cases a phase of resettlement outside hospital – often back in their own home.

Death from strokes occurs more commonly in the north of the country than in the southern counties of England, and men and women are equally affected in terms of frequency. The average

general practitioner will see some four or five new cases of stroke each year, and as many as 500 may be admitted to the average district general hospital in the same period.

Contributory factors

A high blood pressure (hypertension) in a young or middle-aged person, even without symptoms, means that he or she will be more likely to suffer from a stroke later in life. Mild or moderate hypertension in older people may also involve an additional risk of a stroke, although this is a little uncertain at present, and several studies are in progress to investigate whether or not this really is the case; in the meantime many doctors feel that it is sensible to take the precaution of treating a high blood pressure in an old person, although in many ways it is still a matter for debate.

There are other diseases which predispose old people to an above-average risk of having a stroke, such as an abnormality of the heart rhythm, especially if associated with a damaged heart valve It is often necessary for a patient with this condition to take blood-thinning medicine for the duration of his or her life in order to minimize the chance of a clot forming in the heart and subsequently being carried off in the bloodstream to the brain where it may block an artery Other major factors contributing to a cerebrovascular accident include diabetes and abnormalities of fat in the blood, and there are of course also many other medical conditions which can give rise to the symptoms and signs of a stroke. The rest of this section will concentrate on those caused by vascular conditions, since they are by far the commonest.

In most elderly people who have had a stroke, brain damage is caused by a decrease or complete cessation of the blood supply to part of the brain. More infrequently, haemorrhage into the brain substance causes a stroke. Both result in the death of brain cells, but when this is caused by failure of blood to reach the brain tissue it is called cerebral infarction (infarction derives from the Latin word meaning 'to stuff into'), as this is commonly caused by obliteration of the artery as a consequence of arteriosclerotic degeneration, abnormal clotting, or thrombosis and emboli from

elsewhere, as mentioned earlier. The exact cause in an individual patient may be uncertain, and sometimes a combination of factors is involved. However, cerebral haemorrhage occurs less commonly than infarction and is usually associated with a high blood pressure and may involve a previously damaged or abnormal blood-vessel.

Many people suffer what is to all intents and purposes a 'mini' stroke which is caused by a temporary inadequacy of blood flow to a particular area of the brain This condition is known as a transient ischaemic attack and is of short duration but often recurrent. The afflicted person makes a complete recovery within twenty-four hours, and the attack is probably mainly caused by small emboli arising in the heart or from an area of degeneration in the wall of an artery. They are carried by the bloodstream to the brain where they block a blood-vessel but eventually resolve, allowing blood to flow again The onset of these attacks is commoner with increasing age, and although they leave no permanent disability they indicate a greater than average risk of having a full stroke at some time in the future. Modern advances in knowledge and treatment make it possible to reduce the risk of this in some cases.

Consequences of a stroke

A person who has had a stroke will have disabilities which reflect the damage caused to the normal functioning of the part of the brain which has been affected. It is not intended, however, to discuss in detail here the different syndromes associated with damage to different brain areas, but the following account will describe the commoner results of a stroke, irrespective of any particular localization within the brain. It is important to note that damage to one side of the brain usually leads to changes in the opposite side of the body in most cerebro-vascular accidents.

Someone who has had a stroke may be unconscious for a variable period afterwards, and when consciousness has been regained one of the most striking features is usually loss of muscle power, that is the ability to move a limb, since the nerve cells controlling motor function have been damaged. If this affects a leg, walking is impossible or difficult, while if an arm is involved this will obviously

cause problems with dressing, washing, and feeding, for example Commonly both an upper and a lower limb are affected together with the muscles of the same side of the face, and this latter accounts for the drooping corner of the mouth from which food may fall unnoticed when chewing.

Sensation is frequently affected as well, usually in the limbs that are paralysed, and sight is commonly affected too, with a loss of the same part of the visual field, that is what you can see in front of you and to the side, in both eyes. If this affects the right half of the visual field in each eye, the patient gains the impression that he is blind in the right eye, but careful testing will show that he can see things to his left-hand side with both eyes, including the right one. This is important since it is clearly not to his advantage to be in a bed with his left side against the wall if he can only see things on his left-hand side

Speech is affected in a variety of ways, and most usually there is difficulty in forming words properly, leading to slurred speech (known as dysarthria) which is really a mechanical problem as it is the nerves to the tongue and muscles of speech which are affected. Another common problem is difficulty in thinking of the correct word when wishing to name an object, for example being unable to recall the word 'pen' and describing it as 'a thing you write with'. This is called dysphasia and is due to damage to one of the centres in the brain which controls speech. Both dysarthria and dysphasia are as frustrating for the sufferer as for his helpers, but have to be borne with tolerance and understanding.

Confusion, inability to control bowels and bladder, and emotional instability are also the sequels of many strokes.

Complications

There are many complications of a stroke, some of which can occur early on; for instance, the stroke may interfere with the swallowing mechanism and the protective reflex which stops us from inhaling liquid or swallowed material into the lungs. This is the reflex which causes the sensation of coughing or choking when food goes down the wrong way, and if it does not work properly it is possible

for the things one normally swallows to pass down the trachea (the main tube to the lungs) and cause pneumonia.

Later on in the course of a patient's recovery thrombosis is a complication that may affect the deep veins of the legs, especially on the paralysed side. In one survey as many as half the people admitted to hospital with a stroke were found to have a deep vein thrombosis, as it is called, although in many instances special tests were necessary for the diagnosis since it is often not apparent on superficial examination. The main danger from clots in the leg veins is that part or all of the clot may break away and travel to the lungs, where it can seriously interfere with the blood circulation and lung function; this is called a pulmonary embolism and is a common cause of death Also important is the effect of the swelling of the limb which often occurs in some cases after a deep venous thrombosis, as it can hamper rehabilitation considerably because it is more difficult to move a heavy, painful swollen leg.

Pressure sores will develop in anyone who does not change position in bed or chair regularly, as continuous pressure on an area of skin leads to its breakdown and the formation of an ulcer or sore. The stroke patient who is unable to move himself, and in whom sensation may also be impaired, is obviously at particular risk of developing a pressure sore, which characteristically affects the skin adjacent to bony prominences, for instance the heel and the bottom of the back (the sacrum). Sores are best prevented by regular turning of an immobile patient to relieve the pressure on the skin before it is sufficiently damaged to lead to its breakdown.

A later complication of strokes is the development of a contracture, which is the fixation of a limb in one particular position. This occurs especially in limbs that are incapable of movement and which are infrequently and, if at all, passively moved, and can be prevented by good physiotherapy. Contractures result from changes in the soft tissues, in particular the muscles, ligaments, and tendons, and to begin with this causes difficulty in moving the limb at one of the joints and eventually means that it is permanently fixed in one position.

There are many other complications of a stroke, secondary to

both the stroke itself and also the consequences of being semi- or completely immobile, and the interested reader is referred to the Bibliography for more detailed discussion.

Treatment

At the moment there is no available cure for a stroke and all treatments are aimed at making the most of the powers of natural recovery, since once brain cells have died the remaining cells are incapable of dividing to replace what has been lost, unlike the situation in many other organs Some of the cells which have been damaged rather than died may well recover, however, and this accounts for much of the improvement which occurs in a person's physical abilities during the recovery period.

One of the most important facets of treating an older person with a stroke is for the doctor to ensure that the sufferer does not have an underlying condition which could have precipitated the cerebro-vascular accident If a remediable or controllable condition is discovered the treatment may well prevent a recurrence. It is also very important to be optimistic initially about the chance of recovery, since many people recover completely from their paralysis.

Rehabilitation after a stroke involves the skills of the physiotherapist, the occupational therapist, and the speech therapist as well as those of the nurse and the doctor. It must be remembered that they have only limited time to give each patient and much can be done by others, including relatives, both in hospital and outside, but when a non-professionally trained person is attempting to aid a stroke patient's recovery it is important that he or she first liaise with the appropriate physiotherapist or occupational therapist The physiotherapist and the occupational therapist have in many ways a very similar job, although in general the physiotherapists concentrate on mobility, including walking, transferring from bed to chair, regaining balance and being able to stand, etc., while the occupational therapist is more involved with retraining in the activities of daily living, such as dressing, and adapting the immediate surroundings in which a patient is going to live.

Although the process can be slow and laborious, it is important to realize that it is often better to encourage a person recovering from a stroke to do things for himself rather than begin to rely upon other people

The British Chest, Heart and Stroke Association performs a very valuable job in this country, both encouraging and financing research into strokes, as well as providing practical help and advice to patients and their relatives.

Outcome

About a third of all people die within the first month after a stroke, a third live for up to five years afterwards, and the remaining third survive longer. It is often difficult to decide whether a person who has just suffered a stroke is going to be in the group with the bad or the better outlook, and each patient has to be carefully judged on individual merits and great care taken when deciding upon the appropriateness of intervening to alter the natural course of any one individual's recovery.

Mrs L P , a 79-year-old housewife, was admitted to hospital after a stroke which completely paralysed her left arm and leg. She also had difficulty in seeing things on her left-hand side. On the second day of her admission she began to recover consciousness and spent the next three weeks undergoing active rehabilitation. The physiotherapist and occupational therapist assisted her to regain full movement in her leg and to be independent as far as mobility and dressing were concerned She recovered only partial function in her arm, but with the help of the occupational therapist was able to learn how to cope with the disabilities and became virtually totally independent of her husband, with whom she returned to live.

21 Medicines and the elderly

The prescription of medicines, especially in the elderly, needs special consideration by the patients and their relatives or attendants, as well as by the doctor, since it will be seen later that many problems in our elders arise from the use of drugs. As they grow older medical conditions may accumulate, and it is natural, especially with the tendency of older people to be a little pessimistic in outlook, for them to complain about their symptoms. The presence of a symptom does not necessarily indicate the need for treatment, and each individual must decide for himself whether his symptoms are severe enough to ask his doctor to consider prescribing a remedy. Many of our elders are taking medications which they could probably do without, that is they would have been able to cope just as well and with very little discomfort if the drug that they are taking had not been prescribed. This commonsense approach to the need for treatment does have one drawback, as there are conditions, such as high blood pressure and sugar diabetes, where the sufferer may not be aware of any symptoms of his condition at all and wonders whether the treatment is really necessary.

In summary, it is necessary for a patient to be guided by his doctor, but if the latter indicates that treatment is not necessary on medical grounds, it is up to the individual to decide whether the symptoms justify medication, and the need will vary from one individual to another, and even from time to time in the same person. The self-prescription of drugs, that is buying them over the counter from a chemist's shop without seeking medical advice first, needs to be considered on similar lines, as side-effects may result from the mildest preparation. Fortunately, few people suffer with serious sequelae.

The body of an older person breaks down many drugs differently from that of a younger one, for instance a lot of medicines and their breakdown products are excreted from the body by the kidneys, which in our latter years may not be as good at their job as they were formerly, even though functioning adequately under normal circumstances. If the same dose of drug is given to an older person as to a younger person it may not be properly eliminated, building up to toxic levels. For this reason many drugs are prescribed in lower doses for old people than for fitter, younger adults.

Another factor which needs to be taken into account before prescribing drugs for an elderly person is the manner in which it will have to be taken Some older people have difficulty in swallowing tablets, and a capsule or liquid form may be easier for them. It is also not uncommon for older people to get confused or forgetful and mistake their drugs in consequence, and some pharmaceutical manufacturers have cleverly attempted to get round this problem. One method is to pack each day's tablets of a particular drug or combination of drugs in separate compartments in a special pack, with each compartment labelled with a day of the week.

Some of our elders are unable to administer drugs to themselves because they may be unable to see, or have arthritis which badly affects their hands, for instance. It is necessary to take this into account when the medicine is first prescribed in order to make appropriate arrangements.

A prescription for a drug is often considered a life-sentence, but in many cases this is unnecessary and the drug could be stopped without harm. It is just as important to decide when to stop a drug as it is to decide when to start treatment, and even powerful drugs like those used to treat heart failure can often be discontinued in due course. This chapter will briefly consider some of the unwanted effects produced by many of the drugs which are commonly prescribed for older people in order to give the reader an increased awareness of the problems likely to be encountered in the elderly.

A lot of drugs are used to treat conditions of the heart and circulation; one of these, digoxin, is a drug which was first discovered in the leaves of the foxglove plant, and was used as a country remedy to treat an irregular pulse. It is prescribed, usually in combination

with other drugs, to treat heart failure, especially when this is caused by certain abnormalities of the heart's rhythm. Older people are often very sensitive to it and may need only a small dose, for instance of the same order of magnitude as that used for children, since too much causes nausea, vomiting, and disturbances of vision and can also actually lead to abnormalities of the heart's rhythm under certain circumstances. The heart is particularly sensitive to digoxin if the body is short of potassium (one of the salts found in blood and body tissues).

Diuretics are commonly prescribed for the elderly, and although they work by affecting the kidney and encouraging it to excrete more fluid they are usually employed in heart failure to remove the excess fluid which accumulates in the body (often manifested as swollen ankles, although this phenomenon can occur for reasons other than heart failure). One major group of diuretics are known as the thiazides and aggravate diabetes and gout, as well as causing excessive loss of body salts. Like all diuretics they can precipitate incontinence by overloading the bladder with fluid, particularly if this happens suddenly. It is often necessary for periodic blood tests to be arranged in a person taking diuretics in order to check upon the levels of the various salts in the body, as some are washed away with the increased output of urine, which is also why it is necessary for most people on diuretics to take a potassium supplement.

High blood pressure is another disease that can be treated with diuretics, although weight reduction in an obese person may either obviate the need for any treatment at all, or reduce the level necessary There are other drugs used in this condition, and one type, called beta blockers since they block nervous activity at sites in the body called beta receptors (to distinguish them from others labelled alpha receptors), may be used. These affect the heart and slow the pulse rate and can in fact slow it too much and lower the blood pressure excessively, as well as cause heart failure and aggravate any tendency to asthma. Sometimes beta blockers are prescribed for people with bad angina pectoris, which is also often treated by tablets called glyceryl trinitrate (nitroglycerine) placed under the tongue. This has few side-effects but produces severe

headaches in some old people and is difficult for others to take as it has to be placed under the tongue as soon as the chest pain develops. It can also be used to prevent angina pectoris if taken before an activity known to provoke it, and is therefore a particularly useful drug.

Most drugs are capable of producing skin rashes and gastro-intestinal upsets in sensitive individuals, and the antibiotics are particularly prone to do this. Some of the newer preparations similar to penicillin can even produce a rash after the patient has stopped taking them! Tetracycline derivatives, another common group of antibiotics, are sometimes prescribed for our elders but are probably best avoided since they are excreted by the kidney and may cause damage if taken by a person with impaired kidney function The one exception to this rule is doxycycline which is not excreted by the kidney and also has the advantage that it need only be taken once daily whereas many of the other antibiotics need to be taken three or four times a day.

Parkinsonism is diagnosed with increasing frequency in our elders (see page 159) and the drugs used to combat it are becoming more commonly prescribed. The first thing to realize about Parkinsonism, and which is often forgotten, is that it can be caused by drugs, and rather than decide which drug to give, a doctor's first task is to see whether the patient is already taking something which may be responsible for producing the symptoms and signs. If so then further medicine is obviously not needed if the offending drug can be stopped; those frequently responsible are sedatives of the phenothiazine group such as chlorpromazine and thioridazine.

If the Parkinsonism is not drug induced then one of a variety of preparations can be prescribed, but all are capable of producing confusion and should be suspected if a course of one of them has been given to an old person who then becomes confused. Preparations containing a substance called L-dopa (levodopa) are very effective and are consequently frequently used in treatment but they can cause other side-effects too, especially gastro-intestinal upset and postural hypotension. Benzhexol is an alternative anti-Parkinsonian agent and is probably more likely than the others to produce confusion, particularly marked by visual hallucinations.

In many of our elders sleeping habits change as they grow older, so it is not uncommon to meet an old person who requests sleeping tablets because he does not think he is getting enough sleep. In reality this is often not the case, but it is rather that he thinks he should still sleep for the same length of time at night as he used to, even though he may now take longer cat-naps in the daytime. Occasionally insomnia can be the symptom of another disease, such as depression, so it is clearly not appropriate to expect that a prescription for sleeping tablets will be given 'on demand'. This is particularly important in older people because they are more prone to the side-effects. Barbiturates, formerly commonly used to induce sleep, are now rarely prescribed because they have been found to cause confusion and like other similar drugs can also 'hang over' into the next day. Some sleeping tablets can even cause nightmares, many others can result in nocturnal incontinence, and there is some evidence that people taking sleeping tablets regularly are more likely to fracture their hip. In general sleeping tablets should be avoided wherever possible and should not be taken habitually but rather to assist in the establishment of a 'going to sleep routine', or to help out during a short period of need.

Steroid drugs are prescribed for a variety of conditions, and can be given in tablet form, by injection, to more localized skin areas as a cream, and as an enema for bowel conditions. It is even possible in certain lung disorders to take them by an inhaler (a small hand-held machine which injects drugs with the air one breathes). The side-effects are more marked with the oral or injected preparations and include high blood pressure, raised blood sugar, increased susceptibility to infection, and the development or aggravation of peptic ulcers, while another serious problem is the bone thinning which often occurs and can result in fractures.

Many of the illnesses occurring in old age are associated with painful symptoms. On the other hand, many conditions which are painful in younger people are painfree in the elderly, for instance the silent heart attack – in many instances heart attacks are not diagnosed in older people because they do not cause any pain. However, this is compensated for by the number of painful conditions that are prevalent among older people, and arthritis is one of

these causes of discomfort, especially the type of arthritis called osteo-arthritis. This is usually first treated by simple analgesics (i.e. pain-killers) which, though not very powerful, have few side-effects, for example paracetamol. Aspirin is also very safe but can cause bleeding from the intestine, especially the stomach, and should not be taken by people known to have a tendency to ulcers or indigestion. Codeine is another simple analgesic, but can cause severe constipation.

There are, however, more powerful and effective anti-rheumatic drugs, such as indomethacin, but they are also unfortunately more powerful at causing side-effects such as nausea and vomiting, bleeding from the bowel, fluid retention, and blood diseases Nevertheless they often have to be used and care has to be taken to monitor any adverse effects.

Insulin therapy is not required by most elderly diabetics, especially if the disease has arisen late in life and is associated with obesity. However, some do need insulin and the major problems are those of who is to administer it and who is to control it. Regularly drawing up and measuring insulin requires an intact intellect, good eyesight, and hands free of arthritis, Parkinson's disease, or other disabling conditions. The urine has to be checked at least daily, and from time to time the blood too. The major 'side-effect' of insulin is coma caused by too much or too little, so it is very often necessary for relatives or the district nurse to administer and control the treatment, which can pose practical difficulties.

Most older people's diabetes is controlled by tablets of which there are two major groups, collectively known as the sulphonylureas and the biguanides. The sulphonylureas, for example tolbutamide, stimulate the pancreas to produce more insulin, but one of them, chlorpropamide, is generally best avoided in older people since it has a tendency to build up in the body, especially if the kidney is damaged, leading to a blood sugar that is too low, and causing confusion or even coma. In addition the sulphonylureas can cause skin rashes and gastro-intestinal upset and other problems.

The biguanides, for example phenformin and metformin, act by increasing the uptake of blood sugar into the muscles, thus lowering the amount in the blood itself, but are particularly prone to

cause stomach upsets, and can also lead to inadequate absorption of certain food substances from the bowel. In addition they are known to upset the body's metabolic processes, leading to a condition called lactic acidosis, which is another cause of coma.

Depression is relatively common in the elderly but often there is a good reason for it, for example bereavement or having to leave the home they have occupied for many years. It is not always necessary to resort to drugs to overcome this type of depression, but when these are necessary a group called tricyclic anti-depressants are commonly employed. They often take two to three weeks to exert their effect and treatment may be necessary for three months or longer, although rarely indefinitely. Different preparations have slightly different properties, for instance as well as having an anti-depressant effect some of them help to induce sleep, disturbances of which may be a feature of a depressive illness. The side-effects include dryness of the mouth, difficulty in passing urine (especially in men), drowsiness, postural hypotension, and confusion.

Mrs Smith, an 82-year-old widow, was taken to her doctor by her daughter with whom she lived She had recently become very incontinent of urine, and for a day or two had been unable to control her bowels On examination the doctor found her to be very constipated but could not find anything else to account for her symptoms Her daughter reported that she thought they had occurred since her mother's arthritis had become worse, but that this was not as bad as it was as she had been taking some tablets which she had bought at the local chemist. The doctor asked to see these and discovering that they contained codeine, he attributed the incontinence to severe constipation caused by the codeine. He prescribed a different drug for the arthritis, persuaded Mrs Smith to stop taking the codeine, and arranged for the district nurse to give her enemas in order to clear out her bowel Three weeks later she was back to normal.

Mr Richardson, a married pensioner of 72, was admitted to hospital because of a fall which had led to a fracture of his femur. He appeared to have been having several falls a day for about six weeks Careful examination failed to reveal any cause for these except that his blood pressure dropped when he stood up, and he felt dizzy for a few moments afterwards. These symptoms of his postural hypotension appeared to have been present since he had become depressed following the death of his son His depression had been treated with anti-depressant drugs which are a potent cause of postural hypotension, and appropriate alteration of his drug regime banished the postural hypotension and his tendency to fall as well Eight

weeks later he was back at home having had his fracture treated successfully and was living independently again.

A 69-year-old lady was admitted to hospital because of excruciating back pain This had prevented her from walking and she had taken to her bed for about a fortnight. An X-ray of her back showed that all her bones had become very thin, and that one of the vertebrae had collapsed. She was taking steroid drugs for arthritis and it was thought that this had aggravated the natural thinning of her bones (called osteoporosis) and led to the collapse of her vertebra.

In conclusion, although drugs are a powerful weapon in the doctor's armamentarium against disease they are also capable of producing illness, and this is particularly true in the elderly who are often taking many different preparations at once It is necessary for everyone involved in their care to regularly review the medicines that they are taking, and especially to consider these as a potential cause of any symptom or disease from which they are suffering. It is also particularly important to remember that the presence of a symptom does not necessarily indicate the need for treatment. Despite the vast catalogue of potential unwanted effects of drugs, the majority, sensibly used, are of great benefit to many of our elders, making possible an independent existence when the alternative may well be institutional or hospital care.

22 Dying

Not all living creatures die. Some simple forms of life, like the amoeba, replicate by a specialized type of division, and one individual becomes two, each of which can repeat the process in turn, and even though many of these organisms do of course perish, this is probably as near to immortality as it is possible to get. For higher forms of life, however, death is a certainty, since life has a fixed span, with an upper limit a little in excess of seventy years for most human beings in the Western world. We can all therefore predict a date when we will not be here, and this stark reality, which may make many readers a little uncomfortable, is reflected in the way we approach the dying, often trying to put the subject to the back of our minds and avoid discussing it. Death is one of the last taboos of the civilized world, and in consequence we frequently fail to rise to the needs of our dying relatives and patients. Perhaps we are afraid to accept someone else's death because it makes us more aware and uncertain about our own. Much of the mental anguish suffered by those who are passing away is caused by the failure of the people around them to accept their dying and help them to come to terms with life's natural conclusion.

Although many people enter hospital to die, many more pass away at home. Inherent in the desire for hospitalization is a belief that hospitals, and in particular doctors and nurses, can take better care of a terminal patient, but this is often painfully untrue, as most doctors and many nurses finishing their training are as unprepared in their attitudes to death as most lay people. This is a field needing greater consideration during a medical person's training, and it is, after all, our job to help a patient die just as much as it is to assist others in recovering from or coping with their illnesses. The number of elderly people is rapidly growing and will

shortly, in a few years, reach its zenith, so we are therefore all going to have to face this problem more frequently in the future.

The management of the dying patient merits a book on its own, and the space available in this chapter allows only the briefest mention of some of the principles, but the reader is referred to the Bibliography if he wishes to explore this subject more fully.

It is easy to think that treating a dying patient consists essentially of physical and medical matters, such as pain relief, but the psychological aspects of dying are of equal importance, and of these the agony of not knowing ranks foremost. Many a patient suspects the worst but is afraid to ask, not simply because he is afraid for himself, but often also because he does not want to cause distress to relatives and others, or be responsible for the possible embarrassment to his medical helpers caused by their having to admit that they are powerless to cure him. It is difficult to accept the inevitability of death without knowing for certain that one is dying, and even more difficult to come to terms with it until it has been accepted. The ability to face death with equanimity and make the most of the time that is left usually requires an untroubled mind. If a doctor or a medical person denies to a patient that he is going to die, the bond of trust between those concerned may be irreparably shattered when the falsehood is discovered, whatever the motives involved, and at no time is this bond so important as it is at the end of life.

Despite all this, there are times when it is not appropriate to volunteer the information to a patient unless it is specifically asked for. To tell or not to tell under these circumstances is an extremely difficult question to counsel on, and each case has to be considered individually. Often it is the relatives who are in the best position to advise on this, and when the time has arrived to let a patient know of his future it is not what you say but how you say it that matters.

Many of our elders will wish to have the attention of their parish priest or hospital chaplain as death draws near, even if they have not appeared to be religiously involved previously. It is important to bring their problems discreetly to the attention of the appropriate minister, so that he may visit and give them the opportunity of his help.

The medical management of terminal illness in our elders is not usually concerned with the prolongation of life, unless it is possible to ensure an adequate quality of life for its duration. This is in many ways a subjective matter, since different people have different expectations in terms of their quality of life, so it is therefore important not to judge the issue on the basis of one's own social and medical standards, but to try to obtain an individual plan to meet as far as is possible the requirements of each patient.

Of the most important roles which the caring professions are expected to fulfil when looking after a person who is dying, two in particular are of paramount importance The first is the treatment of specific symptoms: for example, it is often better to administer pain-relieving drugs regularly than to wait for a person to ask for them, as this implies that they must begin to suffer before they can be relieved of their discomfort. At the same time it is important to allow the intellect to remain as unbefuddled as possible for as long as possible, so that the dying person can make the most of his waking hours.

The second important issue is not to allow the development of secondary disabilities which may interfere with the quality of life, and the pressure sores and contractures which can arise in bed-bound patients are examples of these.

It should be apparent that as great a degree of care and thought has to be put into the care of the dying as into any of the more dramatic branches of medical care. Nowhere is team-work more important, and in no other aspect of medicine is it more important for us all to resume our role as people as well as continuing with our professional functions.

Euthanasia

The dilemma posed by the question of whether euthanasia (mercy killing) is acceptable medical practice is thankfully, at the moment, not within a doctor's medico-legal jurisdiction to answer Doctors, like most other people, are forbidden by law to take life, although it is often their task to assist a patient to die as peacefully and gracefully as possible. The most vociferous proponents of the need to

legalize euthanasia are usually young, or, if elderly, very fit Most of the sick elderly who express a wish to be allowed to die, and who have a condition that can be remedied or alleviated, are subsequently pleased to be alive when the crisis threatening their life has been successfully overcome It is therefore debatable whether anyone other than those who have experienced the possibility of impending death should be allowed to influence the fate of another, or even of him- or herself until actually faced with the decision in reality There is of course no easy guide in moral issues such as these, and probably no right or wrong answer None of us can tell with absolute certainty what the future holds for a sick person, and even a small chance of an acceptable level of existence may well be worth fighting for.

Another major problem is that of who is to decide that the time has come to actively end a person's life Very often the affected person is unable to make a decision, for example because he or she is unconscious or not of sound mind Friends and relatives are often influenced by emotional factors, or are themselves reacting to stress, and the majority of doctors, while happy to help someone die in the appropriate manner and at the right time, would probably not wish to take on the responsibility for killing a person Many doctors also feel that the bond of trust between a patient and his doctor could be jeopardized if the doctor had the authority to prescribe death, as well as attempting to heal or support his patients.

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PART III

The elderly industry

23 The pattern of services

The single most important source of support for old people is the family (see Chapter 7) but its efforts are complemented and supplemented by many diverse groups.

Volunteers

What is a volunteer? The obvious definition is one who gives help to another person without pay, in contrast to a professional, but this would embrace the millions of relatives, friends, and neighbours who help their elders and the title is usually restricted to those who join an organization to help other people to whom they have no personal obligation The people whom volunteers help are neither related to them nor are they friends, at least not at the start of their relationship

Certain voluntary organizations can be found in almost every community The WRVS, the Women's Royal Voluntary Services, not only play a vitally important part in the meals-on-wheels service but have many other activities, notably day centres and lunch clubs The British Red Cross Society organizes home nursing courses for the relatives of old people, and, acting as the agent of the National Health Service, arranges the loan of nursing aids in many parts of the country, as well as helping with meals-on-wheels and having a housing association The St. John Ambulance Association and, in Scotland, the St Andrew's Ambulance Association are also taking an increasing part in welfare work in addition to their traditional interest in first aid The local branches of Age Concern act as pressure groups, as initiators of services such as day centres, and, together with the volunteers working in Citizens' Advice Bureaux, as information centres Volunteers also

play an essential part in the Community Health Council, the consumers' watchdog for health services. Ex-servicemen are helped by the volunteers who run the British Legion and, in a similar fashion, trade unions and employers use volunteers to keep in touch with retired employees. Schools, polytechnics, and universities are doing more and more to help old people, as are churches. The part played by the churches is of particular interest. Before the Poor Law of 1601 a large part of the help for poor old people was provided by the churches, almshouses for example, but as the provision of the state grew the churches' contribution waned. In recent years, however, there has been renewed interest in pastoral work and the training of the clergy has reflected this trend. Churches provide day centres and lunch clubs and help to organize Fish and other Good Neighbour schemes which act in emergencies to support old people at home.

At a national level four organizations are particularly important in harnessing the contribution which volunteers can make – Help the Aged, Age Concern, the Centre for Policy on Ageing (CPA), and the Volunteer Centre. Help the Aged has acted as both pressure group and initiator. It drew the public's attention to heating and housing problems and contributed to the solution of the latter by setting up Help the Aged Housing Association, now called Anchor Housing Association, which is the largest provider of sheltered housing. It is now interested in rehabilitation, the provision of day centres, and the problem of isolation. Age Concern conducts and stimulates research, publishes excellent reports and *Your Rights*, a clear guide to the social security system, and acts as a pressure group. The CPA is interested in many subjects, notably residential care for elderly people and in gerontological research, and the Volunteer Centre is interested in all aspects of voluntary work especially the often complicated relationship between professional and voluntary services. Professionals like voluntary help but the jobs they give volunteers to do are often not those which volunteers find satisfying and these difficulties have been aggravated by the suspicions of the trade unions. They suspect, sometimes with justification, that management wish to introduce voluntary help so

that they can cut down the numbers of staff employed. The Volunteer Centre and the National Council for Social Services have attempted to reduce the friction and promote co-operation and a committee set up by the Joseph Rowntree and Carnegie trusts examined the future of the voluntary organizations, publishing its conclusions in 1977. This report was both confident and challenging, and emphasized that voluntary help should be encouraged not because it was cheaper than professional help but because it was often better.

Health services

Community services

General practitioners One of the most important people in the life of an old person is his doctor A good general practitioner does not only make an accurate diagnosis and treat with care but by his links with the other services he can greatly aid an elder and lighten the burden of her supporters, because it is only he who can refer a person to hospital Most GPs now work in a primary care team composed of a number of GPs – two, three, or four usually – a health visitor, and a district nurse. The team often has links with a social worker and domiciliary occupational therapist.

The pattern of general practice is changing and GPs no longer pay so many home visits In the past the GP often visited all the old people on his list regularly but the increase in the number of old people has been so great that this is no longer possible; however, doctors still visit elderly people if their illness prevents them from going to the surgery or health centre. If an old person cannot reach the health centre because of chronic disability it is sometimes possible to find a voluntary driver to take him to the surgery, but if he is acutely ill the GP should be asked to visit, the ambulance service is not allowed to convey people to a surgery or health centre (see page 106)

Doctors cannot work all the time and all the doctors in a primary care team take their turn of evening and night duty, or a deputy is sometimes employed to cover nights and week-ends. As a result the

doctor who comes is sometimes unknown, and naturally knows less about the elder than her own GP.

People often complain about general practice. They say it is not what it was. It is not, but the world in which the GP works has changed and so must he. Some of the complaints which elderly people and their relatives make about individual GPs also arise from misunderstandings. The GP is in partnership not only with other doctors but with his patients and their relatives, who should try to remember the strain under which he is working. He has many problems on his mind and needs the help and co-operation of his patients and their supporters, be they relatives, neighbours, friends, or other professionals, if he is to help an old person to the best of his ability. Nevertheless some complaints are justified and the activities of the Community Health Councils, in Scotland called the Local Health Councils, have highlighted many serious deficiencies. Some of the problems should diminish because GPs now receive much better training than they did formerly and a higher proportion in future will be aware of, and interested in, the special problems of elderly people.

District nurses (*domiciliary nurses*) The district nurse, sometimes called the domiciliary nurse or home nurse, offers both practical and psychological help. In the district nursing service there are both fully qualified nurses and nursing auxiliaries; the auxiliaries visit an elderly person alone but their work is supervised by the qualified district nurses. In most parts of the country nurses work in primary care teams but they are also members of domiciliary nursing teams which may consist of twenty or more nurses, each of whom works with different primary care teams. This allows a seven-day service to be provided, but means that the same nurse does not always visit the elder. The qualified nurses perform the more highly skilled tasks, for example treating varicose ulcers and giving insulin injections; the nursing auxiliaries give general care, helping with dressing and undressing, bathing and washing. There is also an evening service for people who need help to get to bed and for those who require a pain-killing injection before they can sleep. For patients dying of cancer the Marie Curie Fund can pay for a

nurse to stay at night, and in some areas there is a night sitting service for other conditions District nursing is not only given to old people who live alone Many children find it embarrassing or unpleasant to bathe their parents or deal with incontinence, and it can greatly relieve the strain if a nurse comes in to help with such tasks, both directly and by providing incontinence pads, and in acute illness the expert advice and practical help of a skilled nurse is very valuable for relatives

Nurses are not only there to make the elder more comfortable physically. They are very experienced in the problems of elders and their supporters and are willing and very able to discuss the emotional problems which often affect elderly people and their supporters as a result of physical illness. In 1977 the number of nurses employed in Britain was equivalent to nearly 15,000 full-time staff. Although this represented a 20 per cent increase during the preceding five years the numbers are still insufficient. Many nurses make immense sacrifices They start work early and leave late and they visit in the evenings even though they are officially off duty, but even this commitment does not allow them to give the elderly patients all the nursing they need.

Health visitors Health visitors are fully qualified State Registered Nurses who have trained for an extra year. The additional year of study, which is usually taken after the nurse has worked in hospital for several years, is devoted to the psychology of human development, the study of society and the public services, and preventive medicine Most health visitors are members of primary care teams, one health visitor working with a group of general practitioners Each health visitor is also a member of a team of health visitors, so that her work can be covered if she is off sick or on holiday. Most of the work of the health visitor is with mothers and young children but about one-sixth of her cases involve elderly people. The health visitor does not usually perform any physical nursing, for example she does not bathe the elder, which is the job of the district nurse, although in an emergency the health visitor would help. The health visitor has three main skills to offer: she is trained in preventive medicine, can recognize the early signs

of illness, and alert the GP if she thinks that an old person's physical or mental condition is changing; she can also help the elder and his supporters resolve anxieties and tensions between them by discussion and counselling and is therefore a useful outsider to help everyone see all sides of difficult decisions; finally, she knows what services are available – social security, housing, social, and voluntary services – and how to apply for them.

Obviously this last aspect of her work is similar to some of the tasks done by social workers and there is some overlap between the two professions but the emphasis of health visiting is more concerned with health and with the prevention of problems.

In some parts of the country there are geriatric liaison health visitors working with consultants in geriatric medicine. They are responsible for ensuring that hospital and community services work smoothly together, especially at the time of hospital discharge. If there is no such liaison health visitor, the medical social worker in the hospital will be responsible for all the discharge arrangements.

Chiropodists The deficiencies in the NHS chiropody service are common knowledge. There are not enough chiropodists, and chiropody colleges are barely producing sufficient to replace those who retire let alone meet the needs of the growing numbers of older people. It has been suggested that chiropodists should train others to perform the simpler tasks such as toe-nail cutting, in the same way as dentists use dental hygienists and auxiliaries, but the chiropody profession has been slow to take this approach which would allow many more patients to be treated. This is not because they are opposed to progress but because they are unwilling to pass on their skills until their profession is 'closed'. Medicine, nursing, and dentistry are 'closed' professions, that is it is against the law to call oneself a doctor, a nurse, or a dentist unless one has had a course of training and passed examinations of standards approved by a legally recognized body, such as the General Medical Council. Anyone can buy a packet of razor blades, and a pair of scissors, put up a brass plate bearing the title 'Chiropodist' and make money from unsuspecting elderly people even though they have had no

formal instruction. (Those who have the letters S.R.Ch. – State Registered Chiropodist – after their name can be approached with confidence as they have had three years of training and passed all the examinations.) State Registered Chiropodists are therefore reluctant to train people in the simpler tasks because they know that such people might well go into private practice, causing harm for profit.

If Parliament were to close the profession the training of auxiliary helpers would expand and many more people would be treated but the shortage of fully qualified chiropodists would still remain. An expansion in the number of chiropody training schools is also necessary.

Dentists The skills of the dental profession need little elaboration for everyone has had experience of them. Elderly people, like everyone else, need regular check-ups and dentures should be checked every two years, more often if they become painful (see page 189). The problems faced by many old people are that they are unable to find a dentist who will treat them 'on the NHS' and, even more distressing, that the dentist who has done so for years says that they must become private patients because the fee he is paid for his work no longer covers his costs The goodwill of dentists who treat old people although they make no money from their work, indeed they lose money for some treatments, has shielded elderly people from the problem Furthermore the dentists' goodwill, together with the fact that many old people do not go to have their dentures checked every two years, has hidden this problem from public and political attention The deficiencies were clearly exposed by the Report of the Royal Commission on the National Health Service, which was published in 1979, although the Royal Commission was not able to suggest any simple inexpensive solutions to the problems it had highlighted.

Hospital services for elderly people

Although they are often inadequate, the hospital services for the elderly cover a wide range of different functions The geriatric unit

is usually split into sub-units providing different aspects of care and is not, as is so often assumed, merely a large number of hospital beds for confused elderly patients who are immobile and suffer with many different conditions. Each department aims at maintaining its patients in the community, or enabling them to return there if this is possible, and only in a continuing care environment does one find people who are going to spend what will probably be the remainder of their lives in hospital care. Each of the major sub-divisions of geriatric hospital care will be described in turn. It must be appreciated that in many less fortunate areas some of these facilities may not exist.

Out-patient clinics A geriatric out-patient clinic often takes the form of an assessment clinic, which means that an elderly person who is beginning to experience certain medical, or even social, problems is seen by a senior doctor and a full medical history and examination are undertaken. In addition to this, the social side of an elder's existence will be ascertained, and relatives will have the opportunity to put their point of view. At the end of the assessment, perhaps after the results of the appropriate investigations have been obtained, it is usual for the doctor in charge of the case to have formulated a concept of the patient's medical problems and how these fit into his everyday life in terms of the repercussions on his own existence and that of those who are supporting him. Armed with this knowledge it is possible to arrive at a long-term plan which is appropriate for a particular patient's requirements, although this often has to take into account the inadequate resources that may be available to deal with many geriatric problems. Occasionally purely medical matters are involved, but more often social difficulties need consideration too. The progress that is made is reviewed from time to time in follow-up appointments at appropriate intervals.

In-patient hospital care Many geriatric services divide their hospital care for the elderly into three phases. The first is the acute treatment and assessment of an ill elderly person, the second is a phase of rehabilitation of an acute nature, and the third is a slower stream

of rehabilitation or continuing care. This latter term encompasses those patients who may spend the rest of their days in a hospital ward, and also those who take a long time to become fit enough to be discharged. An acute assessment ward is usually staffed by a team of doctors, nurses, occupational therapists and physiotherapists, a medical social worker, and a speech therapist, and often the patients have access to a clinical psychologist if their doctor believes they have a psychological problem. In addition there are of course the supporting non-medical staff who look after the cleaning, catering, and so on. Here, as elsewhere in most geriatric departments, the medical and paramedical staff work together as a team, usually with a consultant at their head, and every new admission receives precisely the same standard of medical care and assessment that would be required in a younger person. It is particularly important in the elderly to diagnose accurately and fully the underlying medical problems early on in the illness, since they will obviously be more important as a potential bar to going home than they would be in a younger person. The initial assessment involves all the members of the medical team and takes place concurrently with or soon after any urgent medical treatment that may be necessary. It entails getting patients up and about, or at least sitting out in a chair, as soon as possible after their admission in order to be able to measure their capabilities Occasionally the need for this is misunderstood by relatives who think that the medical staff are being unnecessarily unkind but, as is mentioned earlier in this book, bed is a dangerous place to be, particularly if you are elderly.

The initial management is followed by such rehabilitation as is required, often at a reasonably intense level in order to enable those who can reach their potential early to do so, while patients who are not up to this may be transferred to a slower stream ward where the emphasis is still on rehabilitation, although probably at a slower pace. Such a ward may also be the home for a number of continuing care patients, and it is becoming increasingly common to find wards with a mixture of patients of differing levels of ability, as this is thought to increase patient and staff morale and keeps up a spirit of hope in those whose progress is slow. Such a

ward will also have access to the same paramedical and medical services as the more acute ward

Geriatric in-patient care may also involve two different types of short-stay admission. The easiest of these to understand is that which is usually called a 'holiday admission' and is used to give relief to relatives who are having great difficulty in struggling to look after an elderly person, or to enable them to go away on holiday There is also in many geriatric establishments a more frequent intermittent admission scheme which, in some places, is known as the 'floating bed', in which a patient is admitted to hospital for a short period of time, say two to three days, every fortnight or so This gives relief to relatives who are hard pressed and also enables the hospital staff to keep an eye on a particular patient who may be a little at risk The floating bed is really a development in shared care

If an elderly person with an acute illness is to be admitted initially into a geriatric unit it is obviously important that he or she should not be penalized on account of age, but in many units unfortunately the acute geriatric beds are not in the main district general hospital This can lead to difficulty for medical staff in obtaining appropriate investigation and treatment, and also in obtaining adequate or urgent assistance from colleagues in other disciplines, for example surgery Although many people would argue that ill elderly people do not need such facilities, this is a misunderstanding on their part of the functions of medicine, since many elderly people are as active and fit until they fall ill as many younger people, and in some cases more so If it is possible to assist an elderly person to become fit and independent again by means of access to the same acute facilities that a younger person will enjoy, then it is clearly the Health Service's responsibility to ensure that these facilities are available For this reason many geriatric units are now obtaining access to some beds for the acutely ill in the main district general hospital There are of course many old people who fall ill who would not benefit by being admitted to such a facility, and it is up to the doctors concerned both the general practitioner and the hospital doctor, to recognize this and arrange for their admission to an appropriate ward elsewhere.

Day hospitals Many if not most geriatric departments in this country possess one or more day hospitals. Contrary to popular opinion, these are not establishments for looking after old people in the daytime for social reasons, often called most disrespectfully in certain circles 'granny-sitting', but rather for the attendance of people in whom there is a therapeutic need. A day hospital will therefore be used for somebody who does not any longer need to be in hospital and can be managed and can live mainly in his or her own home but may require continuing rehabilitation, attention to a wound, or even further investigation. People are sometimes referred to the day hospital for initial assessment where it is thought that it would be more meaningful for them to be observed over a period of time rather than in the sometimes rushed atmosphere of an out-patient clinic. A good day hospital has access to the same staff as an acute assessment ward since in many respects their functions are very similar, namely helping an elderly person to live in or return to the community.

Community hospitals Most people are familiar with the concept of the little cottage hospital serving a village, a small town, or a similar area. These were initially developed to bring to the residents who supported them most of the types of hospital care that could be provided in a district general hospital, but unfortunately medical care has now become so complex that it is very difficult for a cottage hospital to fulfil such functions, even though surgery still takes place in many of them, as does indeed a certain amount of obstetrics. A new concept has arisen to replace that of the cottage hospital, although in many areas it may eventually mean the adaptation of the existing facilities rather than the provision of a completely new unit. This is known as the community hospital, and its function is to provide care for patients in a complementary manner to the local district general hospital rather than in competition with it, and as far as the elderly are concerned this is often an ideal arrangement. For instance, an old person who has a stroke with some complications may well be admitted to the geriatric department in a district general hospital until the acute phase of his illness is over and then be transferred

back to the community hospital in his area, if one exists, for slower stream rehabilitation Many people with a stroke can be entirely looked after in a community hospital In addition many people who need to spend a long time, if not the remainder of their lives, in hospital can be nursed among their family and friends, and often by people who know them Their day-to-day medical care is directed by the family doctor, which is a further advantage, and in some community hospitals it is also possible to deliver more acute types of care to certain categories of patients as well. Community hospitals usually have access to the same spectrum of paramedical help as a district general hospital, and the family doctors are usually supported by visiting specialists If the catchment area of the community hospital is large enough it is even possible to arrange out-patient clinics there to avoid the local residents having to transport themselves, or be transported, to the local district hospital, and this is obviously a great asset for the elderly. Unfortunately, under the present financial constraints the development of community hospitals is rather slow.

Peripheral hospitals Many geriatricians have to look after patients in isolated peripheral, purely geriatric, hospitals, which are usually suitable only for slow stream rehabilitation or continuing care patients, since it is not often possible to provide adequate medical cover to enable more acutely ill people to be looked after in them. Although in the past some of these have been viewed with concern, they often have many advantages, and the Health Service is now becoming increasingly aware of the significance of the fact that such an institution is often a patient's home, and they are being adapted and decorated accordingly. In many areas they are also being integrated into the community in which they are placed, with the additional advantage that it is sometimes possible to group patients there on a geographical basis and as in the community hospital to try to reduce the amount of time and money spent travelling by relatives and friends. All peripheral units are unfortunately expensive to maintain, and there is often pressure from the Health Service administrators to close them, but this is a matter that needs very careful consideration, and although

it is inevitable that some will close there are probably many others that could equally well remain open.

Home visits Many members of a geriatric team undertake home visits at different times in a patient's illness, and for different purposes. A general practitioner with a particular problem may well ask the geriatrician to see and assess an elderly patient in his or her own home circumstances and surroundings, since this is often a useful way of preventing unnecessary hospital admission and also of allowing the geriatrician to appreciate more readily the difficulties being experienced in looking after a person in the home environment. During a person's hospital stay the physiotherapist and occupational therapist, together with a medical social worker, may take the patient home shortly before it is hoped to discharge him as this is often very helpful when trying to make final arrangements in what may otherwise be a tricky or complicated discharge. After a patient has left hospital he may be visited at home by a geriatric liaison nurse or geriatric liaison health visitor. These are fully qualified nurses, usually with geriatric hospital experience, who are essentially hospital based and have responsibility for liaising between the patient after his return to the community and the hospital staff who were responsible for the discharge. This is a particularly useful procedure where there is some doubt as to the person's ability to manage independently outside hospital, and especially in those circumstances where an elderly person insists on returning home even though it is generally thought by the medical attendants that this is unwise.

The major aim of a geriatric department is to enable the elderly people in its catchment area to be maintained at home as long as is possible This involves careful liaison with the community services and also with the general practitioner and his medical team. Unfortunately, many geriatric departments have an inadequate number of beds to cope with the potential work-load, and at times the community finds itself very stretched in trying to look after, at home, people who may well be better off in hospital. This is a situation that will only be remedied when appropriate facilities and resources are made available for the care of the

elderly, and since the demand made upon the Health Service by the elderly will increase dramatically over the next ten years or so as their numbers rise the problem of resources needs urgent consideration This is particularly important as the greatest rise will be in those over 75 and 80, who are the most frail and most likely to become dependent.

Ancillary workers, technicians, and administrators The health services we have described are those most directly involved with elderly people However, they could not function without the people who are often forgotten ancillary workers such as porters, ward maids, and cleaners; those whose contribution is not fully appreciated, people with technical skills such as engineers or electricians; and those whose contribution is often belittled and derided, Health Service administrators. Without their contributions the experts would not be able to deliver the service they do.

Personal social services

Elderly people benefit from a whole range of social services. Housing and social security are two social services whose contributions are discussed elsewhere (page 74), but when the term 'social services' is used what is usually meant is the personal social services or welfare services.

The Social Services Department and social workers

Many old people are confused by the similarity of the names Department of Health and Social Security and Social Services Department (in Scotland Social Work Department), but they have very different functions The Department of Health and Social Security is based in London with local social security offices concerned with financial help, either national insurance or supplementary benefits (see page 79) Social Services and Social Work Departments are local government services supervised by local councillors, which have four main responsibilities regarding elderly people:

Firstly, the provision of services to help elderly people who wish to live at home, namely home help; meals-on-wheels; lunch clubs and day centres, and the transport to reach them; aids to daily living and house alterations, which are arranged by a domiciliary occupational therapist; telephone installation and the payment of rental; the supply and licensing of television sets and radios; a laundry service for soiled linen These are only the major services. Under the Chronically Sick and Disabled Persons Act (1970) a Social Services Department can, in theory, pay for almost any aid or service which will help a handicapped elderly person live independently. In practice, however, Social Services Departments may have wide powers but they are limited in what they can provide because the amount of money made available by the ratepayers is often insufficient to meet the multitude of demands made by the public on social services.

Secondly, the provision of residential accommodation – old people's homes – and the supervision of private and voluntary old people's homes (page 238).

Thirdly, the provision of information not only about their own services but about all the housing, financial, legal, and voluntary services which can assist an elder and his supporters In this sphere they work in very close co-operation with local Age Concern offices and Citizens Advice Bureaux.

Fourthly, the employment of social workers Much of the time of social workers who work in the community, for the staff running old people's homes are also social workers, is taken up with the functions outlined above, for example a social worker may be called upon to decide whether an individual is eligible to receive one of the domiciliary services. Many social workers do not enjoy this aspect of their work, feeling that the public does not give enough resource to Social Services Departments and that they are placed in the position of rationing these services, of saying 'no' to more people than they are able to help, on the behalf of an ungenerous society. A social worker is sometimes able to improve an elder's physical environment by arranging for the provision of benefits which are available from the Social Services Department but the job of a social worker is not merely one of form-filling. This

can be done by the elder or her relatives or voluntary helpers – the Citizens Advice Bureaux and Age Concern offices are particularly helpful not only in advising people what benefits are available but in helping them find their way through the bureaucratic maze. The skill of a social worker is distinct from her ability to mobilize the services of the Social Services Department. A doctor tries to deal with disorders which arise *in* an old person but a social worker tries to deal with disorders which arise *around* an old person in her social environment and many social workers feel that the best use of their skills is in work with the families of elderly people. There are often tensions in family relationships which create problems that can be resolved only by bringing these tensions out into the open. It is normal for members of a family to feel some anger and resentment towards one another periodically. This usually passes but if an elder becomes permanently disabled and makes demands on his children, resentment may build up. One child may feel angry at her brother and sister because they have left her to do all the caring. This anger can create resentment towards the elder who feels both angry, because his children are not caring for him as he thinks they should, and guilty, realizing he is the cause of family tension. It is this sort of situation that can often be helped by the social worker

Social workers have an extremely difficult and often nerve-wracking job While a social worker is interviewing an old person or a relative she may still be very upset from her previous interview with a mother suspected of baby-battering or some other problem. Some social workers specialize in work with elderly people but most tackle all sorts of social problems, such as those created by mental illness, mental handicap, or physical disability, just as general practitioners tackle all sorts of medical problems The British Association of Social Workers is well aware of the criticism that not all social workers are adequately trained for this part of their work but it is difficult for members of the profession to develop their skill because the funds available for the education and in-service training of social workers are so limited, much more limited than those available for the training of medical students and doctors, and some departments are so short of staff be-

cause of public expenditure cuts that they are unable to devote as much time to the problems of their elderly clients as they would like

Home helps

Home helps do very much more than housework. They provide company and overcome isolation; they encourage the old person and raise her spirits. They keep an eye on the elder's well-being and alert other professionals if they are worried or see a deterioration. A home help is not meant to help the elder dress or undress, bathe or change her clothes if she is incontinent. However, many do help out in emergency because they do not want to see the elder sitting in damp clothes until the district nurse can call. In some areas specially selected home helps do give this type of personal care – they are sometimes called home care assistants – but personal care is primarily the task of the district nurse and the nursing auxiliary (page 222). Many home help services also have a good neighbour scheme. The good neighbour may be a volunteer, or she may receive a modest sum of money to perform small tasks for the elder – for example, prepare lunch on Sunday – but she does not usually do the same type of work as a home help.

The key person in the home help service is the home help organizer. Each organizer is responsible for all the home helps in a certain geographical area. The home help organizer, who works in the Social Services Department, has to assess each application for home help. Her assessment must consider the elder's state of health, her physical and mental ability, her social problems, and degree of isolation. The organizer has to weigh up the difficulties with housework, shopping, and food preparation and must decide to what extent housing problems, such as the lack of a hot-water supply, are contributory factors. To complete the picture she often has to consult other professionals such as the elder's GP, a social worker, or a domiciliary occupational therapist. If the organizer decides that the old person should receive home help, she must work out how much help can be provided and assess how much the elder should pay. The amount of home help that can be provided

is determined by many factors. In some parts of the country it may be less help than the old person or the organizer thinks is necessary because there is sometimes insufficient money to employ enough home helps. Most home help is provided on week-days, during working hours, but it is possible for the Social Services Department to provide help at week-ends and in the evenings. In most local authorities a charge is made for home help, although not for social work, but the charge varies according to the person's income and the poorest receive a free service.

In 1977 the equivalent of more than 50,000 home helps were employed in Britain, an increase of 5 per cent since 1972. The actual numbers of women employed are much greater than this because so many work part time. This huge and compassionate army helped more than half a million elderly people but many more home helps are needed to offer people the hours of help they really require. The home help service is so limited in some parts of the country that some old people have to agree to go into old people's homes although they are only receiving one hour of home help on four or five days a week. We should be working towards a level of service which would allow us to state that no one should need to enter a home to live until he was receiving at least two hours of home help and two visits from a district nurse seven days a week in his own home.

Domiciliary occupational therapists

Even after the best medical treatment and physiotherapy, some disability may remain to handicap the elder in her everyday life, in getting about the house or outside, or looking after herself. Although many people still think that occupational therapists teach basket-work and other types of hobbies to disabled people, this is only partly the truth. Some occupational therapists do not do any of this type of work and for most it is only a small part of their job. Their main task is to help the newly disabled person learn how to accept her reduced capabilities and adapt successfully to an unchanged environment. It is also commonly thought that this is achieved by the provision of mechanical aids, but this is not so. The

main emphasis is on teaching the individual how to adapt, to help her learn new ways of dressing and undressing, washing and housework, and to encourage her in the belief that she can still perform these tasks. As with physiotherapy, much of the benefit of occupational therapy comes from the confidence which the therapist can foster and inspire. If, after she has thought about and learned new techniques from the occupational therapist, the elder is still handicapped, the therapist, or O.T. as she is often called, may consider providing an aid or, if the elder's ability to move about is affected, adapting her dwelling or suggesting that a wheelchair would be helpful.

Because doctors know that certain diseases almost always leave some disability, and many diseases are very disabling during the healing phase even though recovery is eventually complete, they often involve occupational therapists in the management of disease right from the start of treatment.

Most O.T.s work in hospital, but the hospital-based occupational therapist often pays home visits before the patient is discharged from hospital to discuss with the old person and her relatives any alterations and adaptations which she might think necessary. At the time of discharge, however, the hospital therapist usually refers the case to a domiciliary occupational therapist who is based in the community, usually in the Social Services Department.

The O.T. can advise on ways in which the elder could become less dependent. Independence comes not only from aids, wheelchairs, and house alterations but from attitudes. The attitude of the elder is obviously important, but so is that of her supporters. One of the most difficult situations they may have to face is to resist helping the disabled elder who is struggling to perform some task. If she is confident of success then it is comparatively easy. However, if she is frustrated and tearful at the prospect of yet another failure they naturally feel a great urge to do it for her and it may also be quicker, cleaner, and more convenient. The occupational therapist is the ideal person with whom to discuss such feelings as she is experienced in helping disabled people and their supporters through periods of sorrow, frustration, pity, anger, and resentment,

and none of these emotions is uncommon in the supporters of disabled people.

The pattern of community support

Often more than one professional is involved and old people are not infrequently confused by the numbers of people coming to their home, although they usually welcome the company which such visits provide, as well as appreciating the professional services offered. The pattern of home visiting was revealed by one aspect of the immense study of *The Elderly at Home* which was published by the Office of Population Censuses and Surveys in 1978

Table 10 Visits received during past six months

	Type of household (percentage)	
Visits received from	*Lives alone*	*Lives with others*
Doctor	28 4	35 3
Health visitor	5 6	3.8
District nurse	7 6	7 9
Home help	18 9	4 0
"Council welfare officer"[1]	5 9	3 0
Social security official	9 0	4 7
Meals on wheels	6 4	1 0
Mobile library	2 8	2 9
Voluntary organization	2 8	2 6
Minister of religion	17 6	15.6
Insurance man	36 5	53 8
None of these	28 5	23 5
Insurance man is the only visitor	17 0	26.2

[1]This term was not defined and may therefore include social services, housing, and other local authority personnel

Source. *The Elderly at Home* (H.M.S O , 1978).

Old people's homes

In the nineteenth century large numbers of elderly people who could not continue living in their own homes lived in the workhouse or, to be more precise, the General Mixed Workhouse, for elderly men and women used to share the same accommodation as those of all other classes of pauper, for example 'the imbeciles' and 'the vagrants'. In the years between 1890 and 1910 there was an

upsurge of interest in the Poor Laws in general and in the problems of elderly people in particular. A Royal Commission on the Aged Poor reported in 1895, a House of Commons Select Committee considered the College Homes Bill, which described a type of sheltered housing, in 1899, and in the same year another House of Commons Committee considered the plight of the Aged Deserving Poor. In 1909 the first major review of the Poor Laws since 1834 – the Royal Commission on the Poor Laws and Relief of Distress – published two reports, the Majority Report and the better-known Minority Report, which was masterminded by Sidney and Beatrice Webb.

These reports differed in some respects but all were of the opinion that the emphasis of care for aged and deserving poor should be on helping them in the community; that those who were not able to live at home should have special provisions made for them instead of being required to mix with the other occupants of the General Mixed Workhouse; and that husband and wife should not be separated as was the practice with younger families who were admitted to 'the House' Change was slow, however, and many of the more regrettable practices continued until the break-up of the Poor Law in 1948, when the National Assistance Act was introduced.

Part III of this Act was concerned with the provision of 'residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention not otherwise available to them' The Ministry of Health encouraged local initiatives and a new style of old people's homes began to develop, smaller than the old workhouses, more homely and less like barracks, with the emphasis on the needs of the individual rather than on the rules of the system. Those who were admitted to old people's homes in the early days were often quite fit, but as the years have passed the average level of disability of those entering the homes has increased There have been two main reasons for this trend One has been the development of community services – particularly home helps, district nursing, and meals-on-wheels – together with the provision of better housing for elderly people, especially sheltered housing. The second is the change in public

and professional attitudes and these factors have resulted in a situation in which relatives, voluntary workers, and professionals try, and are able, to keep old people out of homes until they are very disabled. Thus when an old person reaches the limits of the support which can be offered by the community services nowadays she will be much more disabled than she would have been were the services only of the amount and type which they were in the first few years following the passing of the National Assistance Act. One-third of all the new admissions to homes are now aged over 85 and most of them are very disabled. The staff have not only to care for them but for the residents already in the home, many of whom are becoming progressively more disabled, and sometimes have to say that the person is not fit enough to come into the home and this often comes as a surprise to the elder's relatives if she is living alone at home or in a sheltered flat with only a warden on call.

The staff are the most important element in a home. It is pleasant to live in a home with nice gardens or comfortable furniture but the physical environment is much less important than the social environment and that is principally created by the staff. The officers in charge of the home are called residential social workers, and they can be considered as the equivalent of the ward sister. Only a small proportion of the officers are trained nurses, for the homes are primarily for people who do not require skilled nursing, but the residential social workers ensure that the care assistants, equivalent to the nursing auxiliaries in a hospital or community nursing services, learn those basic nursing skills which are required. The job of the care assistant is not just to attend to the residents' physical needs but also to be aware of their social, psychological, and spiritual needs.

More than 100,000 old people live in old people's homes run by local authorities. Almost 50,000 more live in private homes and homes run by voluntary organizations such as the Distressed Gentlefolks Aid Association or the Methodist Church. The supervision of these homes is the responsibility of the local authority and the health authority. While there may be occasional scandals which receive publicity the great majority of the private and voluntary homes provide loving and tender care and contribute an invaluable service to the community.

The need for integration

It is important to appreciate that the division of services into health services and personal social services, and the sub-division of each, is artificial. No one can know everything so this pattern of specialization is inevitable but it also has its drawbacks and dangers. Some problems are not solved because each of the professions assumes that it is someone else's responsibility and this can have serious consequences for the old person A common example of that is the person who is considered by social services to be too disabled for a place in an old people's home but is not considered to be ill enough to require hospital care. Although everyone may agree that such a person should be admitted to an institution it is impossible to arrange it so she lives on at home, either alone or with the support of only her elderly husband or daughter.

All the services are short staffed but better co-ordination of the activities of the National Health Service and the Social Services Departments, housing, and other local authority services would improve the lot of elderly people even if the services were not increased. Closer integration of the voluntary services with the official or 'statutory' services is also required. Too often energy is dissipated in quarrels and misunderstandings which should be devoted to solving or alleviating the problems of elderly people. Most medical problems which occur in old age have social consequences and many social problems stem partly or wholly from medical disorders. It is only by working together that the services can make the best use of their skills and scarce resources and do their best for elderly people in need.

PART IV

Looking ahead

24 Our future

In 1951 6 6 million people were over retirement age in Britain, 13 6 per cent of the population By 1981 it is estimated that this will have risen to around nine and a half million, nearly 18 per cent of the population This increase has been most marked in the oldest age groups in which dependency is highest – in 1951 1.7 million were over 75 years old, by 1981 this number will have doubled, and it will have increased again by 1991. In the twenty-first century the numbers will not increase so quickly because the number of babies born from 1920 onwards is lower than the number born towards the end of the nineteenth century and in the years before the Great War At this point it is appropriate and important to emphasize that the rapid growth in the numbers of elderly people owes little to advances in medical science keeping *old* people alive longer but is mainly due to the dramatic reduction in *infant* and *child* mortality which allowed a much higher proportion of young people to reach old age The average life expectation of women aged 65 increased by no more than one and a half years between 1948 and 1973 and the life expectation of men aged 65 did not increase at all

What will life be like for old people in the twenty-first century? Or, to be more precise, what will life be like for us because most of the readers of this book will be elders in the early decades of the twenty-first centu provided there is neither an ecological disaster nor a nuclear wa There are so many imponderable factors that this question is very difficult to answer accurately but it is wise for both individuals and society to think in advance about the problems which may have to be faced in old age rather than waiting until they occur

On the medical front there appears to be little prospect of any

major breakthrough. It is very unlikely that an elixir of life will be discovered to slow down the process of ageing and as most of the diseases which occur in old age are the end results of degenerative changes of many years' duration it is futile to look for any simple cure, in the way which antibiotics cure infections. The best hope for those who wish to be free from diseases of old age lies in their own hands. They should, to give but two examples, abstain from smoking and adopt a diet which is low in fat and sugar and high in fibre to avoid becoming obese.

In other areas there are more hopeful portents of progress. It seems probable that poverty will be less of a problem not only due to further increases in the level of social security but, more significantly, to the increasing contribution of private and occupational pensions to the income of a steadily growing proportion of retired people. Similarly, housing problems will change in nature. A decreasing number of old people will live in substandard dwellings. This will be partly due to the building of new sheltered housing schemes, and partly to the fact that the middle-aged and young people of today live, and therefore will grow old, in better appointed houses than those in which today's elders have grown old. Housing problems will not disappear. Some may become more severe – particularly the cost of repairs and heating for owner-occupiers. Rising energy costs will make life difficult for everyone because very few of the dwellings built since the First World War are adequately insulated. It is to be hoped that the government will help house-owners and landlords to prepare for the new ice age.

In 1978 the government issued a discussion document called *A Happier Old Age* to stimulate debate about these and many other problems and this was followed by the White Paper published in 1980. This initiative was of great significance and should lead to a more co-ordinated approach to the problems of old age and more sensitive education of both volunteers and professionals.

Such practical problems are important and it is reassuring to know that we may look forward to some improvement in certain areas. However, an even more important question remains. What will it be like to be old in the twenty-first century? Will we be respected more than old people are today or will we be despised

and hated as an unproductive burden in an overcrowded world? Will our children be closer to us than the children of today's elders are to their parents or will they regard us as alien and outmoded?

The increased purchasing power of retired people should increase their status but their influence will not adequately reflect the massive power of the pension funds which, in theory, belong to workers and pensioners but which will, in practice, be managed remotely as part of the national economy. If it is improbable that elderly people will be able to marshal and deploy their pension funds to their advantage will they be able to marshal their votes, their political power, for their own ends? The old people of the twenty-first century, ourselves, will certainly be much more assertive individuals than those of today. We will want and demand more because we have been brought up in a different culture, one in which we have not been so frequently bludgeoned and disappointed as that in which today's elders grew old We have learned how individuals and groups can stand up for their rights. Few of us will meekly accept the statement of a social worker or doctor that we 'need' to go into a home when the health and social services are not providing us with even one visit from a home help and district nurse on all seven days of the week Whereas most old people today accept someone else's definition of their 'need' for institutional care many of us will immediately phone our councillor and write to our MP, the local press, the national press, and the television media if anyone tries to use such an argument when we become disabled and require domiciliary services.

Whether or not the elders of the future will organize themselves in political groups, like the Grey Panthers, it seems certain that the elders will not be as meek, grateful, and stoical as our elders are today. In the words of Dylan Thomas's fiery exhortation we will not go gently to our death:

> Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light.
>
> Though wise men at their end know dark is right,
> Because their words had forked no lightning they
> Do not go gentle into that good night.

Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay
Rage, rage against the dying of the light.

Wild men who caught and sang the sun in flight,
And learn, too late, they grieved it on its way,
Do not go gentle into that good night.

Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light.

And you, my father, there on the sad height,
Curse, bless, me now with your fierce tears, I pray.
Do not go gentle into that good night.
Rage, rage against the dying of the light.

Bibliography

There are now a large number of books on the place of old people in society. *Ageing in Mass Society* by J. Hendricks and C. J. Hendricks (Winthrop, 1977) and *Old Age* by Simone de Beauvoir (Penguin, 1977) are useful general texts. The former is easy to read, the latter, which is a tremendous book, is more difficult but repays the work invested with interest. *Why Survive? – Being Old in America* by Robert Butler (Harper & Row, 1975) is a clear and powerful analysis and condemnation of ageism but it should be complemented by the reading of historical studies which demonstrate that life was often little better for old people and was frequently worse in the past. Peter Laslett's book *The World We Have Lost* (Methuen, 1968) challenges the idea that conditions were much better for the elders of the past and David Hackett Fischer's book *Growing Old in America* (Oxford, 1977) draws similar conclusions from American sources. In *Religion and the Decline of Magic* by Keith Thomas (Penguin, 1972) and in Alan Macfarlane's book *Witchcraft in Tudor and Stuart England* (Routledge & Kegan Paul, 1970), hostile attitudes towards poor old people are suggested as being one of the factors leading to old women being accused of witchcraft. The importance of the theories of witchcraft as a means of understanding contemporary attitudes towards older people cannot be overemphasized. Any reader who is particularly interested in the status of and attitudes towards elderly people should read the 1976 Raleigh Lecture on History, titled 'Age and Authority in Early Modern England', which is also by Keith Thomas (*Proceedings of the British Academy*, vol. 62)

The literature of social anthropology contains a great deal of material about old people in non-industrial societies Chapter 3 of Godfrey Lienhardt's book *Social Anthropology* (Oxford. 1964). Chapter 4 of Lucy Mair's *Introduction to Social Anthropology* (Clarendon Press, 1972), and Chapter 6 of the late E E Evans-Pritchard's book on *The Nuer* (Oxford, 1940) are all worth reading

An appreciation of the attitudes of elderly people is, of course, best developed by meeting and listening to elderly people but reading is an

essential complement to the direct approach. The Edwardian world in which many elders were born and brought up is depicted in Paul Thompson's historical study of *The Edwardians* and in Robert Tressell's famous novel *The Ragged Trousered Philanthropists*, and both present a stark contrast to the usual portrayal of the Edwardian era as a 'golden age'.

The books on the First World War are numerous and are essential reading for anyone who wishes to understand the attitudes of old people to suffering and death. Siegfried Sassoon's *Memoirs of an Infantry Officer*, Robert Graves's *Goodbye to All That*, Erich Maria Remarque's *All Quiet on the Western Front*, which is translated from the German, and Henri Barbusse's novel *Under Fire*, a French soldier's account of the War, are all classics but there are many others worth reading. *The First Day on the Somme* by Martin Middlebrook, and *Julien Grenfell* by Nicholas Mosley are particularly good; the former being a reconstruction of the dreadful events of 1 July 1916, the latter the biography of a man who found the War an exhilarating and liberating experience. Vera Brittain's *Testament of Youth* is also excellent. The spirit of these books is caught in two excellent analyses of the literature of the Great War – Paul Fussell's book *The Great War and Modern Memory* (Oxford, 1975) and Jon Silkin's review of the poetry of the Great War, *Out of Battle* (Oxford, 1972). It is of course very important to appreciate the influence of the twenties and later decades but the Great War remains the dominant influence on today's elderly people.

The social problems of elderly people are documented by an increasingly comprehensive and perceptive collection of books, pamphlets, and reports. Age Concern's publications are particularly illuminating and an Office of Population Censuses and Surveys Report on *The Elderly at Home* (H.M.S.O., 1978) provides a very useful review of a wide range of problems Three books which merit special mention are Malcolm Wick's *Old and Cold – Hypothermia and Social Policy* (Heinemann, 1978), R. M. Moroney's analysis of the relative contribution of *The Family and the State* (Longman, 1976), and Peter Townsend's classic on *Poverty* (Penguin, 1979).

The Age Concern publications also cover the services which are provided for older people but a full understanding of the present pattern of services requires an appreciation of their history and evolution. Norman Longmate's book on *The Workhouse* (Temple Smith, 1974), Brian Abel-Smith's history of *The Hospitals 1800–1948* (Heinemann, 1964), and Peter Townsend's book *The Last Refuge* (Routledge & Kegan Paul, 1962) are all worth reading.

The *Textbook of Geriatric Medicine and Gerontology*, edited by J. C. Brocklehurst (Churchill Livingstone, 2nd edn. 1978), covers a wide variety of

subjects in detail, including changes which occur with age, theory of ageing, and community aspects of care of the elderly, as well as geriatric medical topics. A short paperback concentrating on the physical assessment of older people which is most relevant to doctors and nurses is *Assessment of the Elderly Patient* by F. I. Caird and T. G. Judge (Pitman Medical, 1974). *Nutrition and Ageing*, edited by M. Winick (John Wiley & Son, New York, 1976), provides a general description of ageing and nutritionally related diseases.

The Dying Patient, edited by R. W. Raven (Pitman Medical, 1975), does not confine itself to the elderly patient but also considers younger people and children. However, the appropriate sections are worth reading, and the book covers some of the more difficult problems with sensitivity. *Living to be a Hundred*, by I. Felstein (David & Charles, 1973), is an, in places, light-hearted look at some of the problems of ageing.

Medicine in Old Age (B M.A., 1974) is a collection of papers from the B.M.A., each taking a special topic; the book is probably of most use to doctors and nurses. *Drug Treatment of the Elderly Patient*, by F. I. Caird and T. G. Judge (Pitman Medical, 1977), examines the question of prescribing drugs for the elderly. Very useful background reading, although some sections are obviously intended for doctors, is provided by K. Hazell's book *Social and Medical Problems of the Elderly* (Hutchinson, 1976).

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